Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1 61100

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
STREET ADDRESS (If rural give location) 65 E. Main Street

3. NAME OF DECEASED: (Type or Print) (First) Celia (Middle) (Last) Abramson

4. DATE OF DEATH: (Month) Feb. (Day) 22, (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: May 1, 1885

9. AGE last birthday: 67 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): New York, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob Cohen

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Sacred Heart Hosp. Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0
Immediate cause — (a) Rupture of. ventricle — Interval Between Onset And Death: 2 hours

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Myocardial Infarction - recent — 4 days

DUE TO

(c) Myocardial Infarctous - old — 3 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease — 10 years

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/28, 1953, to Feb 22, 1953, that I last saw the deceased alive on Feb 22, 1953, and that death occurred at 12:44 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
S.G. Weisman MD 59 Greene St Cumberland 2/23/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Feb. 24, 1953
NAME OF CEMETERY OR CREMATORY East View Cemetery
LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1953
REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.
24. FUNERAL DIRECTOR ADDRESS John J. Hafer, Cumberland, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
1953
BUREAU V. S.

Within corporate limits

01101

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Penna COUNTY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyndman
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Pearl (Middle) Mae (Last) Albright

4. DATE OF DEATH: (Month) Feb. (Day) 18, (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 12.3.1897

9. AGE last birthday: 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Homemaker

11. BIRTHPLACE (State or foreign country): Hyndman, Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: S.K.Bryant

14. MOTHER'S MAIDEN NAME: Mary E. Howsare

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) O (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: John Albright, Hyndman, Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
4214
Immediate cause (a) Chronic Valvular Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b)
DUE TO
(c)
(481R)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Influenza — 1 wk.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 48, to 2/18/53, 19..., that I last saw the deceased alive on 2/18/53 19..., and that death occurred at ...m., from the causes and on the date stated above.

SIGNATURE John A Topper (DEGREE OR TITLE) MD ADDRESS Hyndman Pa DATE SIGNED 2/19/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF Feb. 21, 1953 — NAME OF CEMETERY OR CREMATORY Hyndman Cemetery — LOCATION (City, town, or county) Hyndman, Pa. (State)

DATE REC'D BY LOCAL REG. Feb. 19, 1953 — REGISTRAR'S SIGNATURE Walter K. Tantz, M.D.

24. FUNERAL DIRECTOR Harvey H. Zeigler, Hyndman, Pa — ADDRESS

VS. A-8 8-51

RECEIVED
FEB 25 1953
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01102

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland

LENGTH OF STAY (in this place): 35 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 Miltenberger Place

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland

STREET ADDRESS (If rural, give location) 4 Miltenberger Place

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) W. (Last) Allender

4. DATE OF DEATH: (Month) February (Day) 9 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: February 5, 1879

9. AGE Last birthday: 74 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Engineer

10b. KIND OF BUSINESS OR INDUSTRY: W.M. RailRoad

11. BIRTHPLACE (State or foreign country): Pettit, West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Allender

14. MOTHER'S MAIDEN NAME: Anna Summerfield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: F. Patrick Allender, Son

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Arteriosclerosis &

DUE TO

(c) infirmities of age

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE) Cumberland Allegany Md.

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/26/52 to 2/9/53, that I last saw the deceased alive on 2/7/53, and that death occurred at 7:30 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

R.H. Collins MD Cumberland Md 2/9/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Feb. 11, 1953

NAME OF CEMETERY OR CREMATORY: McNeely Cemetery

LOCATION (City, town, or county) (State): Hendricks, West Va.

DATE REC'D BY LOCAL REG.: Feb. 11, 1953

REGISTRAR'S SIGNATURE: Winter K. Franz, M.D.

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Maryland

RECEIVED
FEB 17 1953
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01104

DR. JACOBSON

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND
LENGTH OF STAY (in this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 503 ROSE HILL AVENUE

3. NAME OF DECEASED: (Type or Print) (First) MABEL (Middle) M. (Last) BARNES

4. DATE OF DEATH: (Month) FEBRUARY (Day) 14, (Year) 19 53

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): MARRIED

8. DATE OF BIRTH: MARCH 13, 1885

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Jeansville, Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: H. O. MOYER

14. MOTHER'S MAIDEN NAME: SARAH MOYER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
Immediate cause	(a) ~~420.1~~ ventricular embolism (R. side) paralysis L-side	2 days.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Left auricular thrombus — Auricular fibrillation	?
	DUE TO (c) Myocardial disease & decompensation Coronary artery disease	6 years 6 years
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.	Mitral stenosis & hemoptysis	?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov., 19 44, to Feb. 14, 19 53, that I last saw the deceased alive on Feb. 13, 19 53, and that death occurred at 4:55 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Samuel Jacobson Md 50 Pershing St Cumb. Md 2/16/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — **DATE THEREOF** 2/17/53 — **NAME OF CEMETERY OR CREMATORY** Reformed Cemetery — **LOCATION** (City, town, or county) (State) Perkasie Pa.

DATE REC'D BY LOCAL REG. Feb. 16, 1953 — **REGISTRAR'S SIGNATURE** Walter L. Lantz, M.D. — **24. FUNERAL DIRECTOR** Louis Stein Inc — **ADDRESS** Cumberland, Md.

VS. A15 8-51

RECEIVED
FEB 25 1953
BUREAU V. S.

William Corporate Hill Jr.
Frederick

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, #1104

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland,
LENGTH OF STAY (in this place): 1½ hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sacred Heart Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland,
STREET ADDRESS (If rural, give location): 606 N. Centre St.,

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) M. (Last) BECKMAN

4. DATE OF DEATH: (Month) Feb. (Day) 23rd (Year) 19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Sept. 21, 1878	74 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own home	Cumberland, Md.	U. S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
John Rank	Henrietta Schaller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	Mr. Harold Fulk 606 N. Centre St., Cumb. Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
470X Immediate cause	(a) Bronchitis	Began about	Feb 10 '53
DUE TO			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Heavy Cold	Began about	Feb 3-'53
DUE TO			
	(c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — 2 years

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Feb 3, 1953, to Feb 23, 1953, that I last saw the deceased alive on Feb 23, 1953, and that death occurred at 5:30 P. m., from the causes and on the date stated above.

SIGNATURE: R. C. Troaski (DEGREE OR TITLE) M.D. ADDRESS: Cumberland Md DATE SIGNED: 2/25/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/26/53	St. Lukes Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 25, 1953	Wintes K. Beatz, M.D.	Charles L. George	Cumberland, Md.

VS-A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 3 1953
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01105

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 3 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital Frostburg

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 406 Laing Ave

3. NAME OF DECEASED (Type or Print): (First) CORA (Middle) R (Last) BENNETT

4. DATE OF DEATH: (Month) FEBRUARY (Day) 9 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 11, 1886

9. AGE last birthday: 66 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Daniel Murray

14. MOTHER'S MAIDEN NAME: Rebecca Hamsucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) nu (If year, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Miners Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4433

Immediate cause (a) Cerebral hemorrhage — Interval between onset and death: 2 days

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertensive heart disease — 5-6 years

(c) Bronchopneumonia — 2-3 days.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/7, 1953, to 2/9, 1953, that I last saw the deceased alive on 2/8, 1953, and that death occurred at 12:35 A m., from the causes and on the date stated above.

SIGNATURE Hilda Saurbaugh (Degree or title) M.D. ADDRESS 48 Broadway Frostburg Md. DATE SIGNED 2/9/53

23. BURIAL, CREMATION REMOVAL (Specify) Burial — DATE 2/12/53 — NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery — LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REG. Feb. 14 1953 — REGISTRAR'S SIGNATURE Mrs. Nancy D. Roe

24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland Md

Dr. McLane

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01106 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg

LENGTH OF STAY (in this place): life

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 57 Mt. Pleasant St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Maryland — COUNTY: Allegany

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Frostburg

STREET ADDRESS (If rural give location): 57 Mt. Pleasant St.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
REESE		BEVAN	Feb.	10,	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	2-17-1883	69 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired.:	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Superintendent St. Dept.	for City	Maryland	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Daniel Bevan	Harriet Price

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
	161-14-4126	Leslie Bevan, Frostburg, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420 1 Immediate cause (a) Coronary occlusion — Interval Between Onset And Death: Sudden

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Coronary Sclerosis — 2 yrs

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 19 .., to Feb 10, 1953, that I last saw the deceased alive on Jan 5, 1953, and that death occurred at 12:00 Noon, from the causes and on the date stated above.

SIGNATURE (Degree or title): Wm McLane MD — ADDRESS: Frostburg Md — DATE SIGNED: 2-11-53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-13-53	F'bg. Memorial Park	Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR: 2-13-53 — REGISTRAR'S SIGNATURE: Mrs Nancy N. Dee

24. FUNERAL DIRECTOR — ADDRESS: J. R. Durst, Frostburg, Md.

VS. A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01107

Reg. Dist. No. 4

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Dead on arrival at the
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: Md. — COUNTY: Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: New Germany
STREET ADDRESS (If rural, give location): ✓

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Linda	Kay	Bittinger	Feb.	19	1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	single	June 2-1952	0 yrs.	8	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none		Cumberland, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Aaron Bittinger	Etheline Bittinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
no	none	New Germany, Md. (Mother) Etheline Bittinger.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Bronchopneumonia also terminal	4 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) aspiration of (small amount) stomach contents	
(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH.	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
m.		

22. *I certify that I took charge of the remains described above, held an Autopsy *, Inspection *, Inquiry * thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes**, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D. H.V. Deming M.D.		Cumberland, Md.	Feb. 19-1953

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 22 1953	Reformed Church Cem	New Germany, Maryland

DATE RECEIVED BY LOCAL REGISTRAR'S OFFICE	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 20, 1953	Winter K. Fahrney, M.D.	William Armstrong	Grantsville, Md.

20622 #3353

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Type is preferred. Be especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limit

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01108 Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: County Allegany — MARYLAND
City (If outside corporate limits, write RURAL) or Town Cumberland — Length of stay (in this place) 3 Days
Hospital or Institution or Street Address Memorial Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland — Allegany
City (If outside corporate limits, write RURAL and give nearest town) or Town Cumberland
Street Address (If rural give location) 314 Central Ave.

3. NAME OF DECEASED: (Type or Print) (First) Emma (Middle) Jane (Last) Black

4. DATE OF DEATH: (Month) Feb (Day) 5 (Year) 1953

5. SEX: Female — 6. COLOR OR RACE: Colored — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed — 8. DATE OF BIRTH: Unknown, 1872? — 9. AGE last birthday: 80 ? yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife, Dairy one — 10b. KIND OF BUSINESS OR INDUSTRY: — 11. BIRTHPLACE (State or foreign country): Virginia — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Tate — 14. MOTHER'S MAIDEN NAME: Emily —

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) — 16. SOCIAL SECURITY NO.: None — 17. INFORMANT & ADDRESS: Mrs Sarah Bromery, Cumberland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Lobar Pneumonia — 5 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-2, 1953, to 2-5, 1953, that I last saw the deceased alive on 2-4, 1953, and that death occurred at 3:20 AM, from the causes and on the date stated above.

SIGNATURE Arthur F. Jones (Degree or title) M.D. — ADDRESS 329 Cumberland St. — DATE SIGNED 2-7-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Feb 7 53 — NAME OF CEMETERY OR CREMATORY Rose Hill Cem. — LOCATION (City, town, or county) Cumberland — (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 7, 1953 — REGISTRAR'S SIGNATURE Walter K. Dark, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc — ADDRESS "

VS/A15

Within corporate limits: I. m. 7: file C 153 3/4-53 l

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01109 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 203 Penn Ave Cumberland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Cumberland
STREET ADDRESS (If rural give location) 203 Penn Ave

3. NAME OF DECEASED: (Type or Print) (First) Thomas (Middle) Stevenson (Last) Blacklin

4. DATE OF DEATH: (Month) Feb (Day) 18 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct 8, 1864

9. AGE last birthday: 88 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): 678 Passenger Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Retired (R.R.Co.)

11. BIRTHPLACE (State or foreign country): W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Blacklin

14. MOTHER'S MAIDEN NAME: Isabella Moles

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Clarence Blacklin, Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

422.1

Immediate cause (a) Uraemia — 2 wks.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Myocarditis & Arteriosclerosis — 1 yr

DUE TO

(c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 52, to Feb. 18, 1953, that I last saw the deceased alive on Feb. 17, 1953, and that death occurred at , from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED
Clark Durrett - M. D. — Cumberland. — 2/18/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2/20/53 — NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery — LOCATION (City, town, or county) Cumberland (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 20, 1953 — REGISTRAR'S SIGNATURE Walter R. Frantz, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland

VS. A15-1

Within corporate limits DR. LEY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01110

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: ALLEGANY — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND

LENGTH OF STAY (in this place): 7-DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND — COUNTY: ALLEGANY

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND,

STREET ADDRESS (If rural give location): 126 FREDERICK ST.

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	AGNES	G.	BOWER	FEB.	26	19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
FEMALE	WHITE	SINGLE	MARCH 16, 1886	66				

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housework, retired.	Individual Homes	PENNA.	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
JOHN BOWER	MARY COUGHENOUR

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No		None	Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death
84 X		
Immediate cause	(a) Cholemia (Hepatic failure)	1 week
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Biliary Cirrhosis	1 year
	DUE TO (c) Cholelithiasis (including common duct stones and gall stones)	1 year
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Lower nephron nephrosis - Renal shutdown	1 day

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

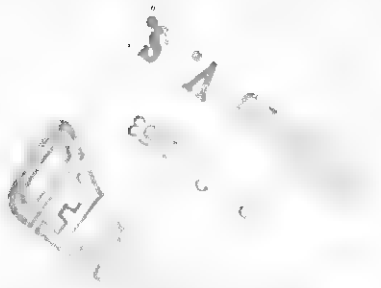
22. I hereby certify that I attended the deceased from Feb 20, 1953, to Feb 26, 1953, that I last saw the deceased alive on Feb 26, 1953, and that death occurred at 1:40 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
A Beverman MD		596 Greene St Cumberland Md	2 27 53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	3/1/53	Glen Savage	Fairhope	Pa.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 28, 1953	Walter R. Fronts, M.D.	Harvey H. Leigler	Hyndman Pa.

VS. A15



Within corporate limits: Yes ☐ No ☐

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01114

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: Cumberland

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sacred Heart Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown

STREET ADDRESS (If rural, give location): 341 Mc Mullen Highway

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month) (Day) (Year)
Francis	Delwyn	Bowman	Feb. 17, 19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS: Hours / Min.
Male	White	Single	9-11-1940	12 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Student	School	Frostburg, Md.	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Delwyn Bowman	Viola McGettigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	Mrs. Viola Bowman Cresaptown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) aplastic anemia	1 yr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO rheumatic heart disease	1 yr.
	(c) DUE TO	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from Feb., 1952, to Feb., 1953, that I last saw the deceased alive on ....., 1953, and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

/s/ Elizabeth Bruns M.D., 55 Greene St. 2/19/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-20-1953	St. Ambrose Cem.	Cresaptown, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 20, 1953	Walter R. Beatty, M.D.	Charles L. George	Cumberland, Md.

VS-A15 8-51

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1112

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. AH

1 PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Cumberland
LENGTH OF STAY (in this place) 54 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS 212 Polk St.

2 USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 212 Polk St.

3. NAME OF DECEASED: (Type or Print) First: Kate (Middle): C (Last): Boyle

4. DATE OF DEATH: (Month) Feb. (Day) 15 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed

8. DATE OF BIRTH: 4/10/1861

9. AGE last birthday: 91 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Keeps House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Jeannville Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Coyle

14. MOTHER'S MAIDEN NAME: Catherine Mullen

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: R.F. Boyle Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

49-3X

Immediate cause (a) Pneumonia — Interval Between Onset And Death: 5 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arterio-sclerosis

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-10-'53, to 2-15-'53, that I last saw the deceased alive on 2-14-'53, and that death occurred at 9.15 '53, from the causes and on the date stated above.

SIGNATURE (Degree or title) Charlotte B. Gardner, M.D. — ADDRESS Cumberland Md. — DATE SIGNED 2-16-'53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2/17/53 — NAME OF CEMETERY OR CREMATORY St Patrick Cemetery — LOCATION (City, town, or county) (State) Cumberland Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 16, 1953 — REGISTRAR'S SIGNATURE Wirtes R. Dandy, M.D. — 24. FUNERAL DIRECTOR Louis Stein Inc. — ADDRESS Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1113

CERTIFICATE OF DEATH

Reg. Dist. No. 10

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Savage
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) JOHN (Middle) (Last) BRODERICK

4. DATE OF DEATH: (Month) Feb. (Day) 23, (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: 9-15-1868

9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: retired brickworker

10b. KIND OF BUSINESS OR INDUSTRY: Brickyard

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Broderick

14. MOTHER'S MAIDEN NAME: Maria Welsh

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: none

17. INFORMANT & ADDRESS: Michael Lynch, Mt. Savage, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocarditis — Interval Between Onset And Death: 2 yrs. 3 mos.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arterio Sclerosis Hypertension — more than 5 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. General Weakness to Old age -

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-16, 1953 to 2-21, 1953, that I last saw the deceased alive on 2-21, 1953, and that death occurred at 9:50 A.M. from the causes and on the date stated above.

SIGNATURE William E. McKelvey (Degree or title) ADDRESS Mt. Savage Md DATE SIGNED 2-24-1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-26-1953 — NAME OF CEMETERY OR CREMATORY St. Patrick's Cemetery — LOCATION (City, town, or county) Mt. Savage, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 2-26-53 — REGISTRAR'S SIGNATURE Veronica O'Donnell

24. FUNERAL DIRECTOR J. R. Durst, — ADDRESS Frostburg, Md.

VS. A15

U.S. BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01114

Within Corporate Limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland

LENGTH OF STAY (in this place) 3 weeks

HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE West Virginia — COUNTY Mineral

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rural near Keyser

STREET ADDRESS (If rural give location) ~~R.F.D.~~ R.F.D. #2-E

3. NAME OF DECEASED: (Type or Print) First	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Bertha	Ellen	Burns	Feb	15	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR: Month / Days	IF UNDER 24 HRS.: Hours / Min.
Female	white	married	Feb. 20, 1905	47		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Grant Co." Va.	U.S. of A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Abidja Rohrbaugh	Sarah Evans

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	None	Herman A. Burns, R33 Keyser," Va.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
600.0 Immediate cause	(a) Uremia	6 Wks.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Malignant Hypertension	1 Yr.
	DUE TO (c) Pyelonephritis	6-7-yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2-2, 1953, to 2-15, 1953, that I last saw the deceased alive on 2-14, 1953, and that death occurred at 6.45 A.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Harold G. Freeman	M.D.	Cumberland, Md.	

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 17, 53	Knobley Cemetery	Antioch, ".Va.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 16, 1953	Walter L. Frantz, M.D.	Rogers Funeral Home,	Keyser, W.Va.

VS. AT5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01115

CERTIFICATE OF DEATH

Reg. Dist. No.....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
LENGTH OF STAY (in this place) 75 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Castle Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Castle Street

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) ----- (Last) Byers

4. DATE OF DEATH: (Month) Feb, (Day) 14, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Jan, 26, 1877

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Byers

14. MOTHER'S MAIDEN NAME: Margaret Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: 166-09-4197

17. INFORMANT & ADDRESS: William Byers Jr. Barton, Md. (Son)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
420.1 Immediate cause	(a) Coronary Occlusion	5-10 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO Arteriosclerosis - Generalized	3-4 years
	(c) DUE TO	
	(d)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:** **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to 14 Feb, 1953, that I last saw the deceased alive on 14 Feb, 1953, and that death occurred at 3 P.m., from the causes and on the date stated above.

SIGNATURE George Richard Jr. (DEGREE OR TITLE) ADDRESS Lonaconing Md DATE SIGNED 2-16-53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Feb. 16, 1953. — NAME OF CEMETERY OR CREMATORY Laurel Hill Cemetery — LOCATION (City, town, or county) Moscow. (State) Md.

DATE REC'D BY LOCAL REG. 2-16-53 — REGISTRAR'S SIGNATURE Jeannette M Boal

24. FUNERAL DIRECTOR George Eichhorn — ADDRESS Lonaconing, Md.

VS/MD 8-51

Within corporate limits DR. STEGMAIER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01116 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A45 8-51

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERALND
LENGTH OF STAY (in this place) 10 HRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN MC COOLE
STREET ADDRESS (If rural, give location) 252 QUEEN STREET

3. NAME OF DECEASED: (First) ~~RETTA~~ Angeretta (Middle) (Last) CAMP

4. DATE OF DEATH: (Month) FEB. (Day) 2 (Year) 1953

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: OCT. 20, 1871

9. AGE last birthday: ~~8~~ 81 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: ~~ADAM X CADAM~~ David WILES

14. MOTHER'S MAIDEN NAME: Eliza Wotring

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
572.5 Immediate cause	(a)	Intestinal Obstruction	2 wks
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	adhesion	
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1 Feb., 19 53, to 2 Feb., 19 53, that I last saw the deceased alive on 1 Feb., 19 53, and that death occurred at 4:40A. m., from the causes and on the date stated above.

SIGNATURE James K. Stegmaier (DEGREE OR TITLE) M.D. ADDRESS Cumberland, Md DATE SIGNED 2 Feb. 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Feb. 4, 1953

NAME OF CEMETERY OR CREMATORY Lance Cemetery

LOCATION (City, town, or county) (State) Near Bayard, W. Va.

DATE REC'D BY LOCAL REG. Feb. 3, 1953

REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR B. & J. Markwood ADDRESS Keyser, West Virginia

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01117

CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. HODGES

1. PLACE OF DEATH:

COUNTY ALLEGANY MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND

LENGTH OF STAY (in this place) 1 DAY

HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE W.VA. COUNTY MINERAL

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN KEYSER, W.VA.

STREET ADDRESS (If rural, give location) 36 CENTRE STREET

3. NAME OF DECEASED: (Type or Print) (First) BABY (Middle) GIRL (Last) CARPENTER

4. DATE OF DEATH: (Month) (Day) (Year) February 15 19 53

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: FEB. 14, 1953

9. AGE last birthday: yrs.

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours 16 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM C. CARPENTER

14. MOTHER'S MAIDEN NAME: MARY E. NOONAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service) None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
7675 Immediate cause	(a)	atelectasis	
	DUE TO		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b)	prematurity (1760 Gms.)	7 hours
	DUE TO		
	(c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 14 19 53, to Feb. 15 19 53; that I last saw the deceased alive on Feb. 15 19 53; and that death occurred at 2:30 A.m., from the causes and on the date stated above.

SIGNATURE AND DEGREE OR TITLE: WM Joyce Hodges, M.D. ADDRESS: Cumberland, Md. DATE SIGNED: 2/16/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 16, 1953	Philos Cemetery	Westernport, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 16, 1953	Walter K. Hardy, M.D.	Rogers Funeral Home	Keyser W.Va.

202331 2343

VS/A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01119

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: West Virginia — COUNTY: Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Romney
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
BABY	BOY	CLINEDINST	FEBRUARY	8,	19 53

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	White	Single	Feb. 5, 1953	yrs.		3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant		Cumberland, Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Wade H. Clinedirst	Blanche Speelman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS
No	None	Memorial Hospital

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Subdural Hematoma	3 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Work ☐ Not While At work ☐	HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 5 Feb, 1953, to 8 Feb, 1953, that I last saw the deceased alive on 8 Feb, 1953, and that death occurred at 4:00 P m., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Leland A. Lawson	MD	63 Grand St. Cumberland	8 Feb 53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 9, 1953	Ebenezer Cemetery	Romney, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Feb. 8, 1953	Wade H. Hantz M.D.	Meryl L. Combs, Romney, West Virginia.

VS. A15

2 232 53424

DR. TOPPER MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

CERTIFICATE OF DEATH

01119 4
Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY ALLEGANY MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 10 HRS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE PENNSYLVANIA COUNTY BEDFORD
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN HYNDMAN
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) EMMA (Middle) (Last) CLITES
4. DATE OF DEATH: (Month) FEBRUARY (Day) 16 (Year) 1953
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED
8. DATE OF BIRTH: APRIL 1, 1883
9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Housework Home
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: ROSS ALBRIGHT
14. MOTHER'S MAIDEN NAME: SARAH BOWMAN
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMB'D, MARYLAND

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
42 x 4
Immediate cause (a) ... DUE TO Chronic Myocardosis
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ... DUE TO
491 x 1 (c)
Interval Between Onset And Death 3yrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Bilateral Bronchopneumonia 1 wk.
19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐
21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/8/53 19 .., to 2/16/53 19 .., that I last saw the deceased alive on 2/16/53 19 .., and that death occurred at 11:20 P.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) John A Topper MD
ADDRESS Hyndman Pa
DATE SIGNED 2.17.53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Feb. 19, 1953
NAME OF CEMETERY OR CREMATORY Hyndman Cemetery
LOCATION (City, town, or county) Hyndman, Pa. (State)
DATE REC'D BY LOCAL REGISTRAR Feb. 19, 1953
REGISTRAR'S SIGNATURE Walter L. Mantz, M.D.
24. FUNERAL DIRECTOR Harvey D. Engle
ADDRESS Hyndman, Pa.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01120

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hauger Jewelery Co. 16 N.Center St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 206 Arch St.

3. NAME OF DECEASED (Type or Print): (First) Theodore (Middle) Dayton (Last) Dailey

4. DATE OF DEATH: (Month) Feb. (Day) 22 (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widower

8. DATE OF BIRTH: Dec.8-1894

9. AGE last birthday: 58 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Repairman - Ward Hauger

10b. KIND OF BUSINESS OR INDUSTRY: Jewelery Co.

11. BIRTHPLACE (State or foreign country): Martinsburg, W.Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Theodore F.Dailey

14. MOTHER'S MAIDEN NAME: Lottie E.Williams, Cumberland, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.I

16. SOCIAL SECURITY NO.: 577-10-8484

17. INFORMANT AND ADDRESS: brother) Wm. M.Dailey, 600 Kent Ave. City

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary occlusion	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

420, 1

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐*

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy , Inspection *, Inquiry * thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes *, accident , suicide , homicide , undetermined .*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md. Feb. 23-1953

BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
burial	Feb.25,1953	Hillcrest Cemtery	Cumberland, Md.

DATE REC'D BY LOCAL REG. Feb. 24, 1953 | REGISTRAR'S SIGNATURE Winter K. Hantz, M.D.

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01126

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 8-51

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCoole
LENGTH OF STAY (in this place): 71 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: McCoole
STREET ADDRESS (If rural, give location): - - - - - -

3. NAME OF DECEASED (Type or Print): (First) LEONARD (Middle) VANCE (Last) DAYTON

4. DATE OF DEATH: (Month) Feb (Day) 12 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 22 April 1881

9. AGE last birthday: 71 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carmen

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): McCoole, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Roland S. Dayton

14. MOTHER'S MAIDEN NAME: Eliza Dayton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — **(If Yes, give war or dates of service)** - - - -

16. SOCIAL SECURITY NO.: 705-09-7259

17. INFORMANT & ADDRESS: Mrs L. V. Dayton, McCoole, Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause (a) Coronary Thrombosis — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) arteriosclerosis — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: (a) 12 hours

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify): no

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED: While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 12, 1953, to Feb 12, 1953, that I last saw the deceased alive on Feb 12, 1953, and that death occurred at 2.15 m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

T. C. Griffin MD Keyser W. Va. 2-14-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Feb 14, 1953

NAME OF CEMETERY OR CREMATORY: Dayton Cemetery

LOCATION (City, town, or county) (State): Allegany Co, Maryland

DATE REC'D BY LOCAL REG.: Feb 16, 1953

REGISTRAR'S SIGNATURE: Mrs Jon C. Kelly

24. FUNERAL DIRECTOR — ADDRESS: E. S. Boal, Westernport, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01122

CERTIFICATE OF DEATH

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 4 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lonaconing
STREET ADDRESS (If rural, give location) Jackson Street

3. NAME OF DECEASED (Type or Print): (First) William (Middle) (Last) Dohme

4. DATE OF DEATH: (Month) Feb, (Day) 12. (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept. 3, 1872

9. AGE last birthday: 80 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal mine

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jesse Dohme

14. MOTHER'S MAIDEN NAME: Mary Ellen Shillingberg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. William Smith. (Daughter) Lonaconing, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

33 DX

Immediate cause (a) Cerebral Thrombosis — Interval between onset and death: 2-3 d.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerotic Disease - Cerebral & Coronary — 10-15 yrs.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-9, 19 52, to 2-12, 19 53, that I last saw the deceased alive on 2-12, 19 53, and that death occurred at 7 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Jerry Richards Jr. M.D. ADDRESS Lonaconing DATE SIGNED 2-17-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 15. 1953 — NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery — LOCATION (City, town, or county) (State): Moscow, Md.

DATE REC'D BY LOCAL REG. 2-18-53 — REGISTRAR'S SIGNATURE Mrs. Nancy N. Roe

24. FUNERAL DIRECTOR: George Eichhorn — ADDRESS: Lonaconing, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01123 Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND; CITY (If outside corporate limits, write RURAL) OR TOWN Cumberland; LENGTH OF STAY (in this place) 3 days; HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Hospital Cumberland

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland — COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural give location) 251 N. Mechanic St.

3. NAME OF DECEASED: (First) Lloyd (Middle) David (Last) EcKenrode

4. DATE OF DEATH: (Month) Feb. (Day) 24 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: 12/20/1890

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Serviceman in Mfg Dept.

10b. KIND OF BUSINESS OR INDUSTRY: Kelly Springfield Tire Co.

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William EcKenrode

14. MOTHER'S MAIDEN NAME: Ida FicKes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) War I

16. SOCIAL SECURITY NO.: 218-12-5116

17. INFORMANT & ADDRESS: Sacred Heart Hospital

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

3 IX

Immediate cause (a) DUE TO: apoplectic Stroke — 3 days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: arteriosclerosis — 1 yr

(c): none

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: none

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-21 ..., 1953, to 2-24 ..., 1953, that I last saw the deceased alive on 2-24 ..., 1953, and that death occurred at 9:30 AM, from the causes and on the date stated above.

SIGNATURE (Degree or Title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2/26/53 — NAME OF CEMETERY OR CREMATORY St Lukes Cemetery — LOCATION (City, town, or county) (State) Cumberland Maryland

DATE RECD BY LOCAL REGISTRAR Feb. 26, 1953 — REGISTRAR'S SIGNATURE W.K. Frank, M.D. — 24. FUNERAL DIRECTOR ADDRESS Louis Stein Inc. Cumberland, Md.

VS A15

Within corporate limits: DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01124

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND. — LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural, give location) 527 Dryer Ave.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
Craig	Duane	EVANS	FEB.	7	19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday: yrs.	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	Infant	FEB. 3, 1953		4	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
None	None	Cumberland, Maryland	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
NORMAN W. EVANS	PATRICIA MAE ZEMBOWER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.: (If Yes, give war or dates of service)	17. INFORMANT & ADDRESS:
No	None	MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause: 756.2 (a) Congenital Atresia Ileum.

DUE TO

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last: (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY: (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3 Feb., 1953, to 7 Feb., 1953, that I last saw the deceased alive on 7 Feb., 1953, and that death occurred at 10:25A m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Fuller B. Whitworth M.D. — ADDRESS 123 Bedford St. — DATE SIGNED 8 Feb 53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/8/53	St. Patricks	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 8, 1953	Winter R. Mark, M. D.	H. Wayne George	Cumberland, Md.

2023/81401

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01125 Reg. Dist. No. 4

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 10/29/52
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Garrett
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Frostburg (Finzel, Md.)
STREET ADDRESS (If rural give location) Route #2

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) Ellen (Last) Finzel

4. DATE OF DEATH (Month) (Day) (Year) February 16, 1953

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: May 14, 1880
9. AGE last birthday: 72 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Homemaker for brother.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland (Garret)
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Henry Finzel
14. MOTHER'S MAIDEN NAME: Sarah McKenzie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
4 2.1 Immediate cause	(a) Pulmonary Hypostasis	48 hrs.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Chronic Myocarditis	?
	(c) DUE TO Cerebral Arteriosclerosis	?
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Secondary anemia	?

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 29, 1952, to Feb. 16, 1953, that I last saw the deceased alive on Feb. 16, 1953 and that death occurred at 12:45 p.m. from the causes and on the date stated above.

SIGNATURE (Degree or title) James E. McLean M.D. ADDRESS 49 Greene St. DATE SIGNED Feb. 17/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Feb. 18 1953
NAME OF CEMETERY OR CREMATORY Hill Crest Bur. Park
LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 18, 1953
REGISTRAR'S SIGNATURE Winter K. Hartz, M.D.
24. FUNERAL DIRECTOR ADDRESS John J. Hafer, Cumberland, Md.

VS. A15

RELEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01126 Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) MARYLAND Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 502 Bedford St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 502 Bedford St.

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) (Last) Frantz

4. DATE OF DEATH: (Month) Feb. (Day) 18 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 4 1881

9. AGE last birthday: 71 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Maintenance Work

10b. KIND OF BUSINESS OR INDUSTRY: Sacred Heart Hosp.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Frantz

14. MOTHER'S MAIDEN NAME: Laura Rice

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Orville Cosgrove, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 600.0 (a) Pyelonephritis — Interval Between Onset And Death: 1 year

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Retention Burse — 2 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 18, 1952, to Feb 18, 1953, that I last saw the deceased alive on Feb 17, 1953, and that death occurred at 10.30 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) Ludwik Prevoznik's Jr M.D. ADDRESS Cumberland, Md DATE SIGNED 2/20/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2/21/53 NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery LOCATION (City, town, or county) Cumberland (State) Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 21, 1953 REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR Louis Stein, Inc ADDRESS Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11127

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

VS. 415 8-51

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Easton

LENGTH OF STAY (in this place) 32 yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS —

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Easton

STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print)	4. DATE OF DEATH: (Month) (Day) (Year)
George Christian Frenzel	Feb 28 1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Single	24 Sept 1870	82 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal Mine	Barton, Md	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
August Frenzel	Elizabeth Shubart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	—	None	Frederick Frenzel Balto. Md. 2131 Ducelond ST

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
443X Immediate cause	(a) Ulcerated Hypertension, DUE TO	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) Arteriosclerosis, DUE TO	
	(c)	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1/1, 1952, to 2/28, 1953, that I last saw the deceased alive on 3/15, 1953, and that death occurred at 2 A.M. m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Chas Reamer MD

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-3-53	Laurel Hill Cemetery	Allegany Co, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-3-53	Marion L. Kelly	E.S. Bear, Westernport, Md.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01128 Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Near Oldtown Md. — LENGTH OF STAY (in this place) 61 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt 1 Paw Paw W. Va.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Near Oldtown Md.
STREET ADDRESS (If rural, give location) Rt 1 Paw Paw W. Va.

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Woodin (Last) Gillam

4. DATE OF DEATH: (Month) Feb (Day) 9 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Mar 22, 1874

9. AGE last birthday: 78 yrs. — IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) general farming

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country) Claneysville Pa

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: ? Oldstown

14. MOTHER'S MAIDEN NAME: Caroline Gillam

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 233-09-3365

17. INFORMANT & ADDRESS: Mrs. John W. Gillam, Rt #1 Paw Paw, W.Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

			Interval Between Onset and Death
Immediate cause	(a)	Coronary Rupture / Thrombosis	10 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b)	Coronary deficiency - Hypertension	Years
	DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-10-52, to 1-31-53, that I last saw the deceased alive on 1-31-53 and that death occurred at 3:05 P.M., from the causes and on the date stated above.

SIGNATURE J S Armstrong M.D. (DEGREE OR TITLE) ADDRESS Paw Paw, W.Va. DATE SIGNED 2-4-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Feb 12, 1953 — NAME OF CEMETERY OR CREMATORY Oldtown Cemetery — LOCATION (City, town, or county) Oldtown (State) Md.

DATE REC'D BY LOCAL REG. Feb 14 1953 — REGISTRAR'S SIGNATURE Marie N. Twigg

24. FUNERAL DIRECTOR John F. Hafer — ADDRESS Cumberland Md.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01123 Reg. Dist. No. 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Rural Cresaptown
OR TOWN R.F.D. 5, Cumberland
LENGTH OF STAY (in this place) Mrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS R. F. D. 5, Winchester Road

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Cresaptown R.F.D. 5, Cumberland
STREET ADDRESS (If rural give location) Winchester Road

3. NAME OF DECEASED: (Type or Print) (First) EDWARD (Middle) FREDERICK (Last) GRABENSTEIN

4. DATE OF DEATH: (Month) Feb (Day) 18 (Year) 1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	widower	12-31-1867	85 yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
retired farmer	own farm	Maryland	USA

13. FATHER'S NAME: Justice Grabenstein

14. MOTHER'S MAIDEN NAME: Margaret Monday

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	none	Edward Grabenstein, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Arteris Sclerosis — several years

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Myocardial Degeneration — several months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 13, 1953, to Feb. 18, 1953, that I last saw the deceased alive on Feb 15, 1953, and that death occurred at 4:20 A.M. from the causes and on the date stated above.

SIGNATURE W.M. McLane (Degree or title) MD ADDRESS Cumberland Md DATE SIGNED 2-19-53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-20-1953	St. Peter & Paul Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 19, 1953 — REGISTRAR'S SIGNATURE [illegible]

24. FUNERAL DIRECTOR Louis Stein Inc ADDRESS Cumberland, Md.

RECEIVED
FEB 24
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH 01130

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING. WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the cause of death clearly and legibly.

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Hill Top Drive

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport; STREET ADDRESS (If rural, give location): Hill Top Drive

3. NAME OF DECEASED (Type or Print): (First) ~~XXXXXX~~ Mary (Middle) Evelyn (Last) Hanlin

4. DATE OF DEATH: (Month) Feb (Day) 16 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 23 Dec 1858

9. AGE last birthday: 94 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Murphy

14. MOTHER'S MAIDEN NAME: Anna O'Haver

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Mrs. O. Wilson, Westernport, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42?.1

Immediate cause (a) Acute Cardiac Failure due to

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic myocarditis — About 5 years

(c) Arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): H. V. Deming, MD — ADDRESS: Cumberland, Maryland — DATE SIGNED: 2/16/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 17 Feb 1953 — NAME OF CEMETERY OR CREMATORY: Murphy Cemetery — LOCATION (City, town, or county) (State): Garrett County Maryland

DATE REC'D BY LOCAL REG.: Feb 16, 1953 — REGISTRAR'S SIGNATURE: Mrs Jean C. Kelly

24. FUNERAL DIRECTOR: E. S. Boal — ADDRESS: Westernport, Maryland

VS. A15A

RELEASE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01131

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport,

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 317 Maryland Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport,

STREET ADDRESS (If rural, give location): 317 Maryland Avenue.

3. NAME OF DECEASED: (Type or Print) (First) Dorothy (Middle) (Last) Heatley.

4. DATE OF DEATH: (Month) (Day) (Year) Feb. 10, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Oct. 22, 1866.

9. AGE last birthday: 86 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Stakeford, England.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Charlton

14. MOTHER'S MAIDEN NAME: Margaret Morgan.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Margaret Green.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

442K

Immediate cause (a) Cardio Renal Disease — 5 yr

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Prolapse of Bladder

DUE TO

(c) Uremia

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 19 53, to Feb 10, 19 53, that I last saw the deceased alive on Feb 10, 19 53, and that death occurred at 10:45 p.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

James A. McGuire M.D. Piedmont, West Va. Feb. 11, 1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Feb. 13, 1953.

NAME OF CEMETERY OR CREMATORY: Philos Cemetery.

LOCATION (City, town, or county) (State): Westernport, Alle. Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 12, 1953

REGISTRAR'S SIGNATURE: Mrs Jane C. Kelly

24. FUNERAL DIRECTOR ADDRESS: W. Grant Hellick Jr. Piedmont, W.Va.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01132

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age if especially important. Physicians: please write the causes of death clearly and legibly.

VS. A-1

1. PLACE OF DEATH: COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; MARYLAND; LENGTH OF STAY (In this place) Most of lifetime; HOSPITAL OR INSTITUTION OR STREET ADDRESS 125 W. First St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 125 W. First St.

3. NAME OF DECEASED (Type or Print): (First) Anna (Middle) Elizabeth (Last) Henry

4. DATE OF DEATH (Month) (Day) (Year): February 9, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 23, 1891

9. AGE last birthday: 61 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Hampshire Co., W. Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Durst

14. MOTHER'S MAIDEN NAME: Caroline Day

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: Walter Henry Sr., 125 W. 1st. St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Diabetes Mellitus — Interval Between Onset and Death: Sudden dea

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) " " — 5yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURRED While at work ☐ Not while at work ☐ HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ", Inspection ☒, Inquiry " thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ", suicide ", homicide ", undetermined ".*

SIGNATURE (Degree or title): H. V. Deneen M.D. ADDRESS: Cumberland, Md DATE SIGNED: Feb 9 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial DATE THEREOF: Feb. 12, 1953 NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park LOCATION (City, town, or county) (State): Cumberland Maryland

DATE REC'D BY LOCAL REGISTRAR: Feb. 10, 1953 REGISTRAR'S SIGNATURE: Walter R. Hartz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01133 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A45

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town) Cumberland
LENGTH OF STAY (in this place) —
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) First: Baby (Middle): Boy (Last): Hiveley

4. DATE OF DEATH: (Month) Oct (Day) 5 (Year) 1953

5. SEX: MALE | 6. COLOR OR RACE: White | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single | 8. DATE OF BIRTH: Oct 5 53 | 9. AGE last birthday: — yrs. | IF UNDER 1 YEAR: Months — Days — | IF UNDER 24 HRS.: Hours — Min. 7

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: None | 10b. KIND OF BUSINESS OR INDUSTRY: None | 11. BIRTHPLACE (State or foreign country): Cumberland Md | 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John W Hiveley | 14. MOTHER'S MAIDEN NAME: Lorraine Kenneth

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No | (If Yes, give war or dates of service) — | 16. SOCIAL SECURITY NO.: None | 17. INFORMANT & ADDRESS: John W Hiveley Corriganville

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

770.0
Immediate cause (a) Erythroblastosis Fetalis
DUE TO
Antecedent causes (s) Disenses or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Rh Neg Blood Factor
DUE TO
(c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20 AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19..., to ....., 19..., that I last saw the deceased alive on ....., 19....., and that death occurred at 7:30 PM from the causes and on the date stated above.

SIGNATURE Fuller B Hurley (Degree or title) MD ADDRESS 23 Bedford St DATE SIGNED 6 Oct 53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Oct 6 53 | NAME OF CEMETERY OR CREMATORY Greenmont | LOCATION (City, town, or county) Cumberland | (State) Md

DATE REC'D BY LOCAL REGISTRAR Oct 6, 1953 | REGISTRAR'S SIGNATURE Interment Permit | 24. FUNERAL DIRECTOR James Stem Jr | ADDRESS Cumberland Md

2023244382

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport

LENGTH OF STAY (in this place) 60 Yrs

HOSPITAL OR INSTITUTION OR STREET ADDRESS 223 Walnut St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport

STREET ADDRESS 223 Walnut St (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) Andrew (Middle) Hotchkiss (Last)

4. DATE OF DEATH: (Month) Feb. (Day) 24 (Year) 1953

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	5/22/1885	67 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner	Coal mine	Scotland	U.S.A.

13. FATHER'S NAME: Andrew Hotchkiss

14. MOTHER'S MAIDEN NAME: Mary Cavanaugh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Andrew Hotchkiss-Westernport.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

		Interval Between Onset and Death
450.0 Immediate cause	(a) Uremia	7 days
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Chronic Nephritis	2 yrs
	DUE TO (c) Arterio Sclerosis - generalized	2 yrs.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 16, 1953, to Feb 24, 1953, that I last saw the deceased alive on Feb 24, 1953, and that death occurred at 8:10 P m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Thomas Reines, M D Westernport Md 2/26/53

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town or county)	(State)
Burial	2/27/53	Philos Cem.	Westernport	Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 27, 1953	Mrs Jos C. Kelly	Ellsworth S Boal	Westernport,

VS. A15 8-51

Within corporate limits DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01135 4

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 22 MINUTES
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE WEST VIRGINIA — COUNTY Hampshire
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ROMNEY
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) BABY (Middle) BOY #2 (Last) HOTT

4. DATE OF DEATH: (Month) FEB. (Day) 27, (Year) 1953

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: FEB. 27, 1953

9. AGE last birthday: yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min. 22

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: None

10b. KIND OF BUSINESS OR INDUSTRY: Cumberland

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: ALFRED G. HOTT

14. MOTHER'S MAIDEN NAME: SHIRLEY E. JUDY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

761.5 Immediate cause

(a) Second twin - cord in tight "Half hitch around ankle.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

DUE TO (b) Prematurity.

DUE TO (c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-27-1953, to 2-27-1953, that I last saw the deceased alive on 2-27-1953, and that death occurred at 5:20 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm Joyce Hodges, M. D. — ADDRESS Cumberland, Md. — DATE SIGNED 2/28/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2/28/53 — NAME OF CEMETERY OR CREMATORY Bethel cemetery — LOCATION (City, town, or county) Hampshire County (State) near Romney, W. Va.

DATE REC'D BY LOCAL REGISTRAR Feb. 28, 1953 — REGISTRAR'S SIGNATURE Walter R. Kantz, M. D.

24. FUNERAL DIRECTOR Keith Shaffer — ADDRESS Romney W. Va.

VS-A15

2123/72382

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

CERTIFICATE OF DEATH

01126

Reg. Dist. No. 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ace is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, nr. Oldtown
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Rt. 1, Oldtown, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural, nr. Oldtown, Md.
STREET ADDRESS (If rural give location): Route 1, Oldtown, Maryland

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) (Last) Humbertson

4. DATE OF DEATH: (Month) February (Day) 18 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: April 5, 1882

9. AGE last birthday: 70 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY: ~~Dairy farm~~ General farming

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Howard Humbertson

14. MOTHER'S MAIDEN NAME: Amanda Burton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Frank Humbertson, Rt. 1, Oldtown, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) ... Bronchogenic Carcinoma — Interval Between Onset And Death: 2 yrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) ... DUE TO

(c)

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) / — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/15, 1953, to 2/18, 1953, that I last saw the deceased alive on 2/18, 1953, and that death occurred at 2/18/53, 11:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Benedict Skiturelic M.D. — ADDRESS R2 Cumberland 2nd — DATE SIGNED 2/19/53

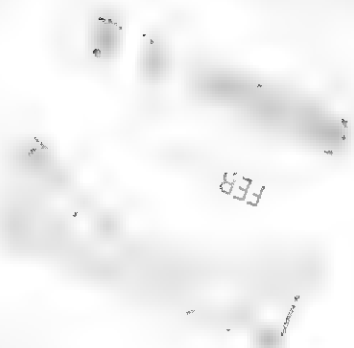
23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: February 21, 53 — NAME OF CEMETERY OR CREMATORY: Pleasant Grove Meth. — LOCATION (City, town, or county) (State): Near Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 20, 1953 — REGISTRAR'S SIGNATURE: Marie D. Twigg

24. FUNERAL DIRECTOR: John J. Hafer, Cumberland, Maryland — ADDRESS

VS. A15

B



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01137 Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Frostburg
LENGTH OF STAY (in this place) life
HOSPITAL OR INSTITUTION OR STREET ADDRESS 10 Beall St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
STREET ADDRESS (If rural give location) 10 Beall St.

3. NAME OF DECEASED: (Type or Print) (First) CORA (Middle) (HANSON) (Last) HUNTER

4. DATE OF DEATH: (Month) Feb. (Day) 16, (Year) 19 53

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 9-7-1883

9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Frostburg, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H. Hanson

14. MOTHER'S MAIDEN NAME: Frances Duggan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT & ADDRESS: Wm. Hunter, Frostburg, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

155X

Immediate cause (a) Carcinoma of Gall Bladder DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death: Several Month

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Dec 1952

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Gall Bladder

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept., 1952, to Feb 16, 53, that I last saw the deceased alive on Feb 16 1953, and that death occurred at 6:30 P, from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm Lane MD ADDRESS Frostburg Md DATE SIGNED Feb 18 1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2-19-1953 NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 2-19-53 REGISTRAR'S SIGNATURE Mrs Nancy N. Roe

24. FUNERAL DIRECTOR J. R. Durst, ADDRESS Frostburg, Md.

VS. A15

RECEIVED
U.S.

Within corporate limits

DR. FAW

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01138 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY ALLEGANY — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN CUMBERLAND, MARYLAND

LENGTH OF STAY (in this place) 19 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE W.VA. COUNTY Grant

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ARTHUR

STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) HARRY (Middle) M. (Last) IMAN

4. DATE OF DEATH: (Month) FEBRUARY (Day) 4 (Year) 19 53

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 12/18/1888

9. AGE last birthday: 64 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Agent

10b. KIND OF BUSINESS OR INDUSTRY: Insurance Co.

11. BIRTHPLACE (State or foreign country): PETERSBURG, W.VA.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES W. IMAN

14. MOTHER'S MAIDEN NAME: EMILY COX

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 232-10-5141

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

541.0

Immediate cause (a) Bronchiectasis, suppurative + pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: Jan 30. 1953

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Duodenal ulcer with pyloric obstruction past 5 years.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Jan 23 - Jan 31 - 1953

19b. MAJOR FINDINGS OF OPERATION: Jan 23 - pyloric Obstruction Jan 31 - Obstruction cleared

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 16, 1953, to Feb 4, 1953, that I last saw the deceased alive on Feb 4, 1953, and that death occurred at 1:15 P.m., from the causes and on the date stated above.

SIGNATURE AND (DEGREE OR TITLE) W M Mauk. MD — ADDRESS Cumberland — DATE SIGNED Feb 4 1953

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF Feb. 7 1953 — NAME OF CEMETERY OR CREMATORY Lahmansville Cem. — LOCATION (City, town, or county) (State) Lahmansville, W. Va.

DATE REC'D BY LOCAL REG. Feb. 4, 1953 — REGISTRAR'S SIGNATURE Winter R. Hantz, M.D. — **24. FUNERAL DIRECTOR** Keith Stoffer — ADDRESS Romney W.Va.

Shrunk Funeral Home " "

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01139 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: CUMBERLAND — LENGTH OF STAY (in this place): 13-HRS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Pennsylvania — COUNTY: ALLEGANY Bedford
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Bloomstown, Maryland
STREET ADDRESS (If rural give location): RT.#1

3. NAME OF DECEASED (Type or Print): (First) VELMA (Middle) Marie (Last) IMES
4. DATE OF DEATH: (Month) FEB. (Day) 24 (Year) 1953
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE
8. DATE OF BIRTH: 1/8/1923
9. AGE last birthday: 30 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Machine Operator
10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.
11. BIRTHPLACE (State or foreign country): PENNA.
12. CITIZEN OF WHAT COUNTRY? U.S.A. U.S.A.
13. FATHER'S NAME: KELLY IMES
14. MOTHER'S MAIDEN NAME: ADELL KEEFER
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): nO (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 213-22-2863
17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
757.3 Immediate cause	(a) DUE TO	Uremia	? ?
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO	Cystic Polycystic (Congenital) Kidney Complete Anuria	? ? 1 day.
	(c)	Acute Pancreatitis	1 day

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/24, 1953 to 2/24, 1953, that I last saw the deceased alive on 2/24, 1953 and that death occurred at 7:45 P.M., from the causes and on the date stated above.

SIGNATURE: Samuel Jacobson (Degree or title) — ADDRESS: 50 Pershing St. Cumberland Md — DATE SIGNED: 2/25/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 27 1953 — NAME OF CEMETERY OR CREMATORY: Chancysville Meth. Cem. — LOCATION (City, town, or county) (State): Near Chancysville, Penn.

DATE REC'D BY LOCAL REGISTRAR: Feb 27, 1953 — REGISTRAR'S SIGNATURE: Walter R. Mantz M.D. — 24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Cumberland, Maryland

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11149

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R. D. # 5 Cumberland, — LENGTH OF STAY (in this place) 35 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS Cresap Park

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN R. D. # 5 Cumberland,

STREET ADDRESS (If rural, give location) Cresap Park

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) ELLEN (Last) JEWELL

4. DATE OF DEATH: (Month) Feb. (Day) 27th (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: Feb. 23, 1879

9. AGE last birthday: 74 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Rockingham Co. Va.

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Noah Higgs

14. MOTHER'S MAIDEN NAME: Alice Devers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Beulah Duckworth Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) 420.1 Acute coronary occlusion — 1 hour

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Arteriosclerosis — 1 Year

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-2-, 1952, to 2-27-, 1953, that I last saw the deceased alive on 2-27-, 1953, and that death occurred at 1105 P m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

M.D. 57 Greene St. 3-1-53

23. BURIAL, CREMATION REMOVAL, (Specify): Burial

DATE THEREOF 3/2/53

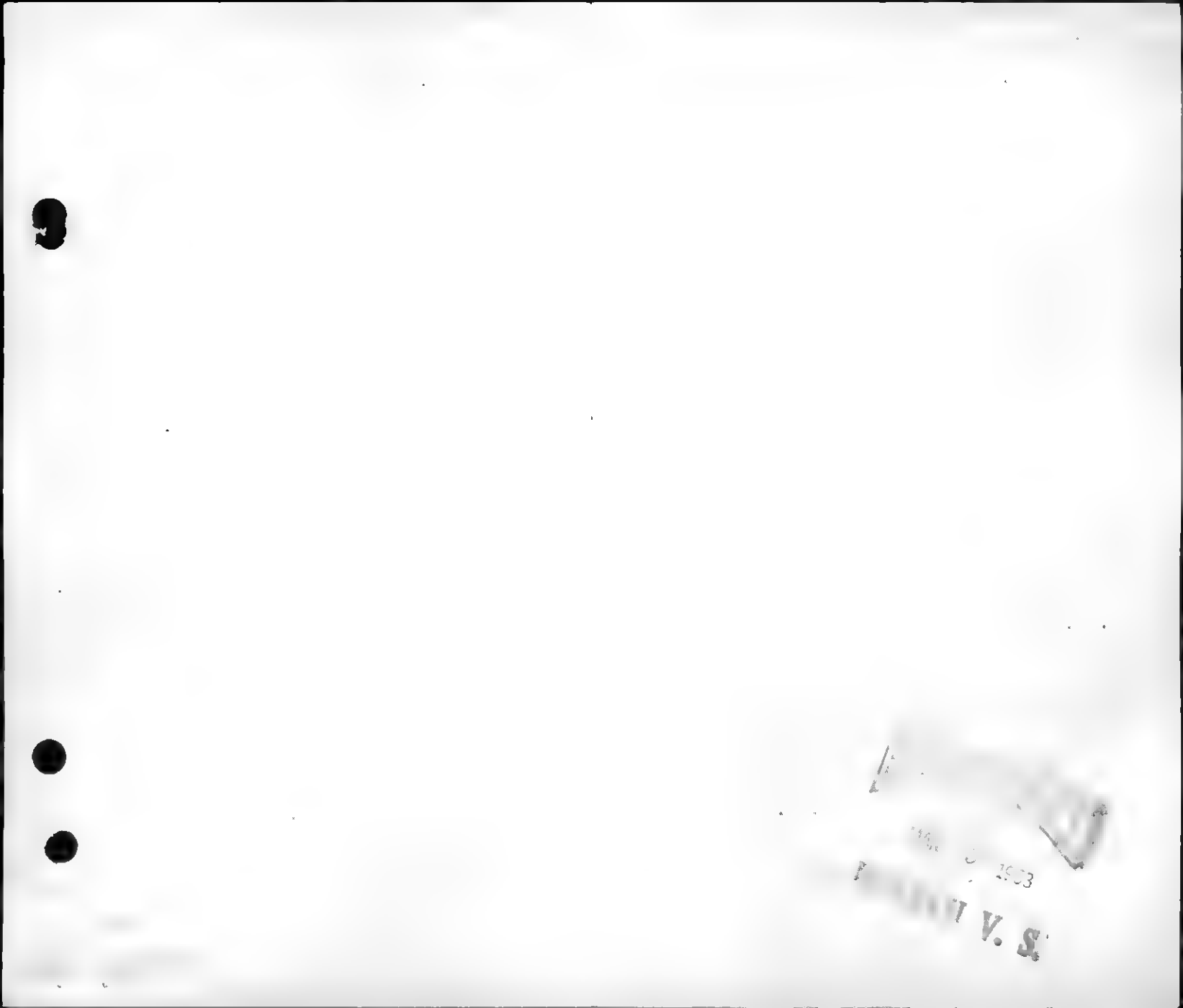
NAME OF CEMETERY OR CREMATORY Hillcrest Cem.

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. March 2, 1953

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR ADDRESS Charles L. George Cumberland, Md.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; LENGTH OF STAY (In this place) 16 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegahy; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland; STREET ADDRESS (If rural, give location) 411 N.Mechanic St.

3. NAME OF DECEASED (Type or Print): (First) Lynn; (Middle) Elmo; (Last) Johnson

4. DATE OF DEATH: (Month) Feb.; (Day) 21; (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married

8. DATE OF BIRTH: June 7-1900

9. AGE last birthday: 52 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith-Bolt & Forge-B&O.R.Ry.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Winston,Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William B.Johnson

14. MOTHER'S MAIDEN NAME: Lizzie Martin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 705-05-4669

17. INFORMANT AND ADDRESS: wife) Lyla Saville Johnson, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary occlusion — Interval between onset and death: at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — about 10 months.

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy __, Inspection*, Inquiry* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes *, accident __, suicide __, homicide __, undetermined __.*

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

H.V.Deming M.D. H.V.Deming M.D. Cumberland,Md. Feb.21-1953

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Feb.24,1953 — NAME OF CEMETERY OR CREMATORY Loar Baptist Cemetery — LOCATION (City, town, or county) (State) Orange,Orange Co. Va.

DATE REC'D BY LOCAL REG. Feb.23,1953 — REGISTRAR'S SIGNATURE Winter R. Hantz, M.D.

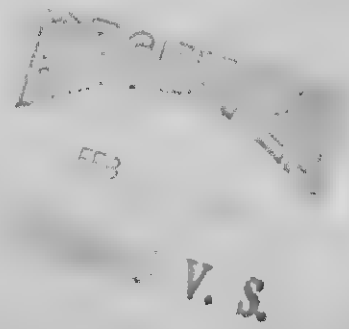
24. FUNERAL DIRECTOR ADDRESS William H. Kight, Cumberland, Md.

K-gbs

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH 31142

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-415A

1. PLACE OF DEATH: COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; LENGTH OF STAY (In this place): 35 yrs; HOSPITAL OR INSTITUTION OR STREET ADDRESS: 17 Fifth St.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md. COUNTY: Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland; STREET ADDRESS (If rural, give location): 17 Fifth St.

3. NAME OF DECEASED (Type or Print): (First) Sulia (Middle) May (Last) Johnston

4. DATE OF DEATH: (Month) Feb (Day) 24 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Married

8. DATE OF BIRTH: March 8-1890

9. AGE last birthday: 62 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Old Home

11. BIRTHPLACE (State or foreign country): Meyersdale, Pa.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Isiac Collins

14. MOTHER'S MAIDEN NAME: Nancy Johnson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: Husband) Charles B. Johnston, Cumberland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Hypostatic congestion of the lungs and	about 1 month.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) malnutrition also had bronchiectasis and	several
	(c) alcoholic cirrhosis	years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy __, Inspection *, Inquiry * thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes *, accident __, suicide __, homicide __, undetermined __.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md. Feb. 25-1953

23. BURIAL CREMATION REMOVAL (Specify): Burial | DATE THEREOF: Feb 27 1953 | NAME OF CEMETERY OR CREMATORY: Woodburn Memorial Park | LOCATION (City, town, or county) (State): Woodburn, Maryland.

DATE REC'D BY LOCAL REG.: Feb 26, 1953 | REGISTRAR'S SIGNATURE: Wirtes K. Wantz, M.D. | 24. FUNERAL DIRECTOR | ADDRESS: James L. Scarpelli, Cumberland Md.

Within corporate limits

STEGMAIER

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct ■g is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:

COUNTY ALLEGANY — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND

LENGTH OF STAY (in this place): 4 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND

STREET ADDRESS (If rural, give location): 1016 ELLA AVE.

3. NAME OF DECEASED: (Type or Print) (First) SHANNON (Middle) LEE (Last) JONES

4. DATE OF DEATH: (Month) FEB. (Day) 13 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: SEPT. 5, 1886

9. AGE last birthday: 66 yrs.

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stationary Fireman

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. RR.

11. BIRTHPLACE (State or foreign country): PENNSYLVANIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JAMES C. JONES

14. MOTHER'S MAIDEN NAME: AMANDA E. CRUPPER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes — (If Yes, give war or dates of service) W.W.I

16. SOCIAL SECURITY NO.: 705-09-9945

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

451 X

Immediate cause — (a) Ruptured aneurism of Aorta, abdominal — DUE TO

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) marked arteriosclerosis — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: 1 wk

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:**

20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED: While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8 Feb., 19 53, to 13 Feb., 19 53, that I last saw the deceased alive on 13 Feb., 19 53, and that death occurred at 7:50 P. m., from the causes and on the date stated above.

SIGNATURE: James C. Stegmaier — (DEGREE OR TITLE) M. D. — ADDRESS: Cumberland Md — DATE SIGNED: 14 Feb. 53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Feb. 17, 1953

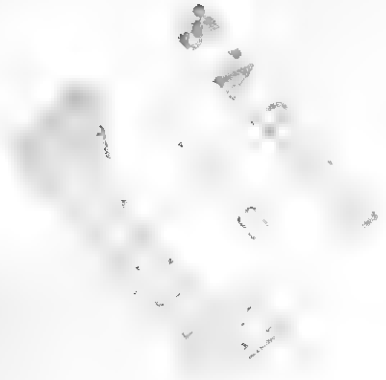
NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 16, 1953

REGISTRAR'S SIGNATURE: Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01144 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give name of town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 18 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 51 Henderson Ave

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 51 Henderson Ave

3. NAME OF DECEASED: (Type or Print) (First) Hazel (Middle) (Last) Kinch

4. DATE OF DEATH: (Month) Feb (Day) 8 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct 2 1889

9. AGE last birthday: 63 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Altoona, Blair Co, Pa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas J. Patterson

14. MOTHER'S MAIDEN NAME: Victoria Palmer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: W. S. Kinch, 51 Henderson Ave., Cumberland, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4138

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: 2 yrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ..... DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — 2 yrs

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 26, 1952 to Feb 8, 1953, that I last saw the deceased alive on Feb 8, 1953, and that death occurred at 4-35 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) K. A. Spivakis Dr MS — ADDRESS Cumberland, Md — DATE SIGNED 2/9/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Feb 11 1953 — NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery — LOCATION (City, town, or county) Hagerstown Washington County (State) Md.

DATE REC'D BY LOCAL REGISTRAR Feb. 10, 1953 — REGISTRAR'S SIGNATURE Walter R. Stantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: William H. Kight, Cumberland, Md.

VS. A15-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01145

Reg. Dist. No. 8

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A45

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland; LENGTH OF STAY (in this place) 50 Yrs.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Dans Rock Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Midland; STREET ADDRESS (If rural, give location) Dans Rock Road

3. NAME OF DECEASED (Type or Print): (First) Howard (Middle) Ashbey (Last) Lease

4. DATE OF DEATH: (Month) Feb, (Day) 26, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug, 13, 1873

9. AGE last birthday: 79 yrs. If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (Bleacher) Wva. Pulp &

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Morgantown Wva.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James T. Lease

14. MOTHER'S MAIDEN NAME: O-Crist

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: 216-07-6004

17. INFORMANT AND ADDRESS: Henry Lease (Son) Midland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset and Death
Immediate cause	(a)	Coronary Occlusion	1-2 d.
4 Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	Arteriosclerotic Heart Disease	3-4 yrs.
	(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec., 1952, to 26 Feb, 1953, that I last saw the deceased alive on 25 Feb, 1953, and that death occurred at 7 a.m., from the causes and on the date stated above.

SIGNATURE: Lon J. Richards Jr. (Degree or title) MD ADDRESS: Lonaconing, Md. DATE SIGNED: 2/26/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: March 1, 1953 | NAME OF CEMETERY OR CREMATORY: Laurel Hill Cemetery | LOCATION (City, town, or county) (State): Moscow, Md.

DATE REC'D BY LOCAL REG. 2-28-53 | REGISTRAR'S SIGNATURE: Jannette M Boak

24. FUNERAL DIRECTOR: George Eichhorn, Lonaconing, Md. ADDRESS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01146 6

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport,
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Kooken Nursing Home, 437 Walnut Street,

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Westernport,
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED: (Type or Print) (First) Dillon (Middle) (Last) Leatherman.

4. DATE OF DEATH: (Month) (Day) (Year) Feb. 11, 1953.

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: March 11, 1882.

9. AGE last birthday: 70 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - Retd. farm owner

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Purgittsville, W.Va.

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John N. Leatherman.

14. MOTHER'S MAIDEN NAME: Martha Liller.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Victor Liller.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1, 1952, to 2-11, 1953 that I last saw the deceased alive on 2-11, 1953 and that death occurred at 1000 a.m. from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

James A. Wolverton Jr. M.D. Piedmont W.Va 2-12-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: Feb. 13, 1953.

NAME OF CEMETERY OR CREMATORY: Old Pine Church Cemetery,

LOCATION (City, town, or county) (State): Purgittsville, W.Va.

DATE REC'D BY LOCAL REG.: Feb 12, 1953

REGISTRAR'S SIGNATURE: Benjamin C. Kelly

24. FUNERAL DIRECTOR ADDRESS: W. Harold Feddeff Piedmont, W.Va.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01147 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A10 7

1. PLACE OF DEATH:
COUNTY [illegible]
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN [illegible]
LENGTH OF STAY (in this place): MARYLAND; 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS: [illegible] Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE [illegible] COUNTY [illegible]
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN [illegible]
STREET ADDRESS (If rural give location): 134 [illegible]

3. NAME OF DECEASED: (First) [illegible] (Middle) (Last) [illegible]
4. DATE OF DEATH: (Month) 2 (Day) 3 (Year) 19
5. SEX:
6. COLOR OR RACE:
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH:
9. AGE Last birthday: 17 yrs. IF UNDER 1 YEAR Month Days; IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country)
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME:
14. MOTHER'S MAIDEN NAME:
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) DUE TO: Intestinal Obstruction — Interval Between Onset And Death: 3 Days

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: Ventral Hernia — years

(c)

560.3

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 27, 1953, to Feb. 3, 1953, that I last saw the deceased alive on Feb. 3, 1953, and that death occurred at 12:45, from the causes and on the date stated above.
SIGNATURE (Degree or title): Wm C Lane MD
ADDRESS: Frostburg Md
DATE SIGNED: 2-4-53

23. BURIAL, CREMATION, REMOVAL (Specify)
DATE THEREOF: 6 1953
NAME OF CEMETERY OR CREMATORY
LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REGISTRAR: 2-6-53
REGISTRAR'S SIGNATURE: [illegible]
24. FUNERAL DIRECTOR
ADDRESS

DR. W. F. WMS.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01118 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

COUNTY: ALLEGANY — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: CUMBERLAND

LENGTH OF STAY (in this place): 2 HRS,

HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL H OSPITAL MEMORIAL AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MD. COUNT: ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Near Cumberland, Rural

STREET ADDRESS (If rural, give location): RT. #1 LaVale

3. NAME OF DECEASED: (Type or Print) (First) CHARLES (Middle) W. (Last) LESTER

4. DATE OF DEATH: (Month) (Day) (Year) FEB. 5, 1953 19

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED	DEC. 11, 1908	44 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Signal Supervisor	B. & O. RR	MARYLAND	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
JOHN LESTER	ELIZABETH BEATTY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
NO	705 05 1682	MEMORIAL HOSPITAL CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 331K

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral Hemorrhage	About
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Malignant	4 Hrs.
	DUE TO (c) Hypertension?	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

22. I hereby certify that I attended the deceased from 1-16, 1953, to 2-5, 1953, that I last saw the deceased alive on 2-5-53, and that death occurred at 2:10 AM m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

W. F. Williams M.D. Cumberland 2-5-53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 8, 1953	Hill Crest Cemetery	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS
Feb. 7, 1953	Walter L. Frantz, M.D.	William H. Kight, Cumberland, Md.

VS. A15 8-51

Dr. G. S. Weisman

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 04140 5

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS: A15 8-51

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland rural
LENGTH OF STAY (in this place) 23 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3 mi west of Cumberland

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland - rural
STREET ADDRESS (If rural, give location) 3 mi west of Cumberland

3. NAME OF DECEASED: (Type or Print) (First) Walter (Middle) Smith (Last) Light

4. DATE OF DEATH: (Month) February (Day) 19 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) Married

8. DATE OF BIRTH: 3 Dec 1879

9. AGE last birthday: 73 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman ret.

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Great Cacapon, W. Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Light

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) - - - -

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Stanley Hanna, Keyser, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1

Immediate cause (a) Acute Myocardial Failure — DUE TO — Interval Between Onset and Death: Indefinite

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Acute Myocardial Infarction — DUE TO — Interval Between Onset and Death: "

(c) Acute Coronary Insufficiency — Interval Between Onset and Death: "

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis & Hypertensive Heart Disease 7 Years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 46, to Feb 19 53, that I last saw the deceased alive on Jan 15, 1953, and that death occurred at 11:30 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

A. S. Weisman M.D. 37 Greene St Cumberland Maryland 2/20/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: 22 Feb 1953 — NAME OF CEMETERY OR CREMATORY: Philos Cemetery — LOCATION (City, town, or county) (State): Westernport, Maryland

DATE REC'D BY LOCAL REG. 2/20/53

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR — ADDRESS: E. S. Boal, Westernport, Maryland

RECEIVED
FEB 24
BUREAU V. S

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01150

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
LENGTH OF STAY (in this place): 12 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Frostburg
STREET ADDRESS (If rural give location): 148 Washington St.

3. NAME OF DECEASED: (Type or Print) (First) ROY (Middle) (Last) LUCAS

4. DATE OF DEATH: (Month) Feb. (Day) 9, (Year) 19 53

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single

8. DATE OF BIRTH: 12-12-1903

9. AGE last birthday: 49 yrs. IF UNDER 1 YEAR Months | Days; IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: laborer- dye house

10b. KIND OF BUSINESS OR INDUSTRY: Celanese Corp.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Lucas

14. MOTHER'S MAIDEN NAME: Annie Winner

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 213-10-5267

17. INFORMANT & ADDRESS: George Lucas, Frostburg, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

416X

Immediate cause (a) Congestive Heart Failure — Interval Between Onset And Death: 48 hrs.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Rheumatic Heart Disease — 10 yr.

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1949, to Feb. 9, 1953, that I last saw the deceased alive on Feb 9, 1953, and that death occurred at 2:00 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title): John B. Davis, M.D. — ADDRESS: Frostburg, Md. — DATE SIGNED: 2/10/53.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 2-11-1953 — NAME OF CEMETERY OR CREMATORY: F'bg. Memorial Park — LOCATION (City, town, or county) (State): Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR: 2-11-53 — REGISTRAR'S SIGNATURE: Mrs. Hally N. Roe

24. FUNERAL DIRECTOR: J. R. Durst, — ADDRESS: Frostburg, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 011514

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-115 8-51

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 Weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sacret Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural, give location): Robbins, Street.

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) (Last) Lyden

4. DATE OF DEATH: (Month) Feb, (Day) 3 (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Feb, 14. 1871

9. AGE last birthday: 81 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Barton Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Lashbaugh

14. MOTHER'S MAIDEN NAME: Sarah Greenhorn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Robert Cook Lonaconing, Md. (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1 (1637)

Immediate cause (a) Congestive Heart Failure — Interval Between Onset and Death: 2-3 mo.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — DUE TO (b) Arteriosclerotic Heart Disease — 5-10 yr.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Lung. — 3-6 mo.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 19 52 to 2 Feb, 19 53, that I last saw the deceased alive on 3 Feb, 19 53, and that death occurred at 12 01 A.M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) George J. Richards Jr. M.D. ADDRESS Lonaconing Md. DATE SIGNED 2-3-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Feb, 5. 1953

NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

LOCATION (City, town, or county) (State): Lonaconing, Md.

DATE REC'D BY LOCAL REG.: Feb. 4, 1953

REGISTRAR'S SIGNATURE: Walter K. Rank, M.D.

24. FUNERAL DIRECTOR: George Eichhorn ADDRESS: Lonaconing, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01152 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (In this place) 10/21/52
HOSPITAL OR INSTITUTION OR STREET ADDRESS Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) Near Cumberland, Rural
STREET ADDRESS (If rural, give location) Valley Road R.F.D. #3

3. NAME OF DECEASED: (Type or Print) (First) Anna (Middle) E. (Last) Lydinger

4. DATE OF DEATH: (Month) (Day) (Year) February 1, 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: August 2, 1873

9. AGE last birthday: 79 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Maryland (Allegany Co.)

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Nicholas Lydinger

14. MOTHER'S MAIDEN NAME: Margaret Reinhart

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.2

Immediate cause (a) Pulmonary Hypostasis — Interval between onset and death: 72 hrs

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO (b) Chronic Myocarditis — ?

DUE TO (c) Cerebral Hemorrhage — ?

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. General arteriosclerosis — ?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 21, 1952 to Feb. 1, 1953 that I last saw the deceased alive on Feb. 1, 1953 and that death occurred at 9:30 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
Lewis E. McLean M.D. 49 Greene St. 2-2-53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF 2-3-1953

NAME OF CEMETERY OR CREMATORY S.S. Peter & Paul

LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REG. Feb. 2 1953

REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS
Charles L. George Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

53

Reg. Dist. No. 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Especially important. Physicians: please write the causes of death clearly and legibly.

The correct age

1. PLACE OF DEATH: COUNTY Allegany; STATE MARYLAND; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg; LENGTH OF STAY (in this place) 1 hr.; HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md.; COUNTY Allegany; CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Westernport; STREET ADDRESS (If rural, give location) Wood St. Extended Box 276

3. NAME OF DECEASED (Type or Print): (First) Alvin (Middle) Robert (Last) Miller

4. DATE OF DEATH: (Month) Feb. (Day) 13 (Year) 1953

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: Oct. 2-1928

9. AGE last birthday: 24 yrs. If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Light Iron Worker

10b. KIND OF BUSINESS OR INDUSTRY: Const.

11. BIRTHPLACE (State or foreign country): Westernport, Md/

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Leslie Miller

14. MOTHER'S MAIDEN NAME: Mary Louise Bidale

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war, or dates of service): Yes, Air Force 1953

16. SOCIAL SECURITY No.: 213-24-5375

17. INFORMANT AND ADDRESS: Father-Leslie Miller, Westernport, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
827 Immediate cause	(a) Shock, Intra-abdominal hemorrhage due to	1.1/2 hrs
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) a ruptured spleen.	
	(c) Auto accident.	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY * OR CONTRIBUTING * CAUSE OF DEATH | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY #36 highway | near (CITY OR TOWN) Barton (COUNTY) Allegany (STATE) Md.

TIME OF INJURY (Month) (Day) (Yr.) (Hour) Feb. 13/53 P. m. 8.42 | INJURY OCCURRED While at work ☐ Not while at work ☒ | HOW DID INJURY OCCUR? Auto went out of control and turned over.

22. *I certify that I took charge of the remains described above, held an Autopsy * Inspection *, Inquiry * thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes , accident *, suicide , homicide , undetermined .*

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
H.V.Deming M.D. H.V. Deming M.D.	Cumberland, Md.	Feb.14-1953

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/16/53	Phelps Cem.	Westernport, Md

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
2-18-53	Mrs Nancy N. Poe	Ellsworth S Boal	Westernport

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01154

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH — COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
LENGTH OF STAY (in this place): 63Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Jackson Street

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Lonaconing
STREET ADDRESS (If rural, give location): Jackson Street

3. NAME OF DECEASED (Type or Print): (First) James (Middle) Andrew (Last) Miller

4. DATE OF DEATH (Month) (Day) (Year): Feb, 6 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: Aug, 9 1889

9. AGE last birthday: 63 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner

10b. KIND OF BUSINESS OR INDUSTRY: Coal Mine

11. BIRTHPLACE (State or foreign country): Lonaconing, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Miller

14. MOTHER'S MAIDEN NAME: Annie Nicols

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I.

16. SOCIAL SECURITY NO.: 216-07-2678

17. INFORMANT AND ADDRESS: William Miller. Cumberland, Md (Brother)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		Interval Between Onset and Death
Immediate cause	(a) Coronary Occlusion	10 min
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Myocardial Infarction	24 hours
	(c) Arteriosclerotic Heart Disease	

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify):

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY:

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1952, to 6 Feb, 1953, that I last saw the deceased alive on 5 Feb, 1953, and that death occurred at 8 a.m., from the causes and on the date stated above.

SIGNATURE: George Richard D. (Degree or title)

ADDRESS: Lonaconing, Md

DATE SIGNED: 3-6-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Feb, 8, 1953

NAME OF CEMETERY OR CREMATORY: Oak Hill Cemetery

LOCATION (City, town, or county) (State): Lonaconing, Md.

DATE REC'D BY LOCAL REG.: 2-8 53

REGISTRAR'S SIGNATURE: Annette M. Foal

24. FUNERAL DIRECTOR: George Eichhorn ADDRESS: Lonaconing, Md

RECEIVED
FEB 1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Pa. COUNTY Bedford Co.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Bedford
STREET ADDRESS (If rural, give location): Bedford RD 5 Pa.

3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print): Meade R. Miller

4. DATE OF DEATH: (Month) 2 (Day) 10 (Year) 53

5. SEX: M

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 9-28-1952

9. AGE last birthday: yrs. — IF UNDER 1 YEAR: Months 4 Days 12 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Ross Miller

14. MOTHER'S MAIDEN NAME: Rose E Weyant

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: James Ross Miller Bedford RD 5 Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:
7562
Immediate cause (a) Acute Virus Respiratory Infection — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
(b) Congenital Jaundice — 5 Mos
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION:**

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-6-53 to 2-10-53, that I last saw the deceased alive on 2-10-53, and that death occurred at 3:30 P m., from the causes and on the date stated above.

SIGNATURE AND (DEGREE OR TITLE) M.E. Eckerson M.D. ADDRESS 176 Union St Cumberland Md DATE SIGNED 2/11/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF 2-12-53 — NAME OF CEMETERY OR CREMATORY: P.O.S. of A. Cemetery — LOCATION (City, or county) (State): Bedford RD 5 Pa.

DATE REC'D BY LOCAL REG. Feb. 11, 1953 — REGISTRAR'S SIGNATURE Morris R. Frank, M.D. — **24. FUNERAL DIRECTOR** ADDRESS: Charles L. George Cumberland, Md

9V9-99V998

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1454 CERTIFICATE OF DEATH

Reg. Dist. No. 6 4156

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 3 weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: near Cumberland, rural
STREET ADDRESS (If rural give location): Route 3, Knob Road

3. NAME OF DECEASED: (First) WILLIAM (Middle) H. (Last) MILLER
4. DATE OF DEATH: (Month) Feb. (Day) 12, (Year) 1953
5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: April 5, 1880
9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS: Hours, Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Laborer - Retired
10b. KIND OF BUSINESS OR INDUSTRY: Tire industry
11. BIRTHPLACE (State or foreign country): Cumberland, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: William H. Miller
14. MOTHER'S MAIDEN NAME: Addie McClelland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Chester M. Miller, Cumberland, Md.

18. MEDICAL CERTIFICATION

			Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
Immediate cause 177X	(a) Cerebral Arteriosclerosis		6 months
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Carcinoma of Colon	*	2. 1 year History Cancer
	DUE TO (c) Carcinoma of Prostate	*	2.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized Arteriosclerosis	*	2.

19a. DATE OF OPERATION: no
19b. MAJOR FINDINGS OF OPERATION: no
20. AUTOPSY? Yes X No

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED White at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19, 1953, to Feb 12, 1953, that I last saw the deceased alive on Feb 12, 1953, and that death occurred at ..., from the causes and on the date stated above.
SIGNATURE (Degree or title): Samuel G. Wiseman MD
ADDRESS: 59 Greene St Cumberland Maryland
DATE SIGNED: 2/13/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Feb. 15, 1953
NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery
LOCATION (City, town, or county) (State): Cumberland, Md.
DATE REC'D BY LOCAL REGISTRAR: Feb. 15, 1953
REGISTRAR'S SIGNATURE: Winter R. Bantz, M.D.
24. FUNERAL DIRECTOR: William H. Kight, Cumberland, Md.
ADDRESS

* Duration illness approximate - no history available

VS. A15

Within corporate limits DR. ROTH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01157 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
   - COUNTY: ALEEGANY — STATE: MARYLAND
   - CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND, MD.
   - LENGTH OF STAY (in this place): 2 DAYS
   - HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:
   - STATE: MARYLAND — COUNTY: ALLEGANY
   - CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CUMBERLAND
   - STREET ADDRESS (If rural give location): 324 CRAWFORD ST.

3. NAME OF DECEASED (Type or Print): (First) REGINA (Middle) M. (Last) MINNIGH

4. DATE OF DEATH: (Month) FEB. (Day) 22 (Year) 1953

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: JAN. 1, 1885

9. AGE last birthday: 68 yrs. — IF UNDER 1 YEAR: Months Days — IF UNDER 24 HRS: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): ~~PENNA~~ Canada

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No. (If Yes, give war or dates of service): ~~No.~~

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Eugene Minnigh, 324 Crawford St.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

41 X

Immediate cause (a) DUE TO: Pneumonia, bacterial

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO: Congestive heart failure
(c) Rheumatic heart dis

Interval Between Onset And Death: 2 days / unk

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

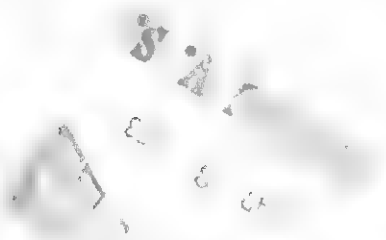
22. I hereby certify that I attended the deceased from Sept, 1952, to 22 Feb, 1953, that I last saw the deceased alive on 21 Feb, 1953, and that death occurred at 12:35 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title): Otis Ralph Roth, M.D. — ADDRESS: Cumberland Md — DATE SIGNED: 2/22/53

23. BURIAL, CREMATION, REMOVAL (Specify): burial — DATE THEREOF: Feb. 26, 1953 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 24, 1953 — REGISTRAR'S SIGNATURE: Wirtes L. Hantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli — ADDRESS: Cumberland, Md.



Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01158 Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 10/5/45
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cresaptown
STREET ADDRESS (If rural give location):

3. NAME OF DECEASED: (First) Thomas (Middle) Jackson (Last) Morton
4. DATE OF DEATH: (Month) February (Day) 18, (Year) 19 53

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 8/7/1864
9. AGE last birthday: 88 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, (Retired): Retired Coal Miner
10b. KIND OF BUSINESS OR INDUSTRY: Coal Mining
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: John Morton
14. MOTHER'S MAIDEN NAME: Margaret Jackson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No — (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Allegany County Infirmary Records

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause	(a) Pulmonary Hypostasis	72hrs
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Chronic Myocarditis	?
	DUE TO (c) General Arteriosclerosis	?
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Senile Deterioration	

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 2, 1953 to Feb. 17, 1953, that I last saw the deceased alive on Feb. 17, 1953, and that death occurred at 1.05 a.m. from the causes and on the date stated above.

SIGNATURE (Degree or title): James E. McLean M.D. — ADDRESS: 49 Greene St. — DATE SIGNED: 2-18-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 20, 1953 — NAME OF CEMETERY OR CREMATORY: Frostburg Mem. Park — LOCATION (City, town, or county) (State): Frostburg, Maryland

DATE REC'D BY LOCAL REGISTRAR: Feb. 20, 1953 — REGISTRAR'S SIGNATURE: Walter R. Frantz, M.D.

24. FUNERAL DIRECTOR — ADDRESS: John J. Hafer, Cumberland, Maryland

VS. A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH 1159

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY: Allegany — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland — LENGTH OF STAY (In this place): 3/4 hrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Md — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 512.1/2 Hill St.

3. NAME OF DECEASED (Type or Print): (First) Dorothy (Middle) (Last) Parker
4. DATE OF DEATH: (Month) Feb. (Day) 19 (Year) 1953

5. SEX: female
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): married
8. DATE OF BIRTH: June 22-1918
9. AGE last birthday: 34 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Emma Nailor

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: Husband) Raymond Parker, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Intra-abdominal hemorrhage due to ruptured — Interval between onset and death: about 1.1/2 hours

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b) lymph node in superior mesenteric artery, also
(c) had T.B. of right kidney, Pericadritis with adhesions.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy *, Inspection *, Inquiry * thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes* ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) | ADDRESS | DATE SIGNED

H.V. Deming M.D. H.V. Deming M.D. Cumberland, Md. Feb. 19-1953

BURIAL, CREMATION OR REMOVAL (Specify) Burial | DATE THEREOF Feb. 22, 1953 | NAME OF CEMETERY OR CREMATORY Susquehanna Cemetery | LOCATION (City, town, or county) Cumberland, Maryland (State)

DATE REC'D BY LOCAL REG. Feb. 20, 1953 | REGISTRAR'S SIGNATURE Walter K. Mantz, M.D. | 24. FUNERAL DIRECTOR AND ADDRESS Louis Stein, Inc., Cumberland, "

DR. LEY

Within corporate limits?

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY ALLEGANY — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND

LENGTH OF STAY (in this place) 14 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND

STREET ADDRESS (If rural, give location) 316 BOND STREET

3. NAME OF DECEASED: (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH: (Month)	(Day)	(Year)
	CECIL	H.	PERDEW	FEBRUARY	7	1953

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED	MARCH 17, 1906	46 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
None	Newspaper Feed Server	MARYLAND	U.S.A.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
MOSE J. PERDEW	ESTA P. IMES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No.	214-05-7522	MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 201X — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Hodgkins Sarcoma

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	INJURY OCCURRED While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
			M.		

22. I hereby certify that I attended the deceased from 2/1, 1952, to 2/7, 1953, that I last saw the deceased alive on 2/6, 1953, and that death occurred at 1:40 A.m., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
Leo N. Ley Jr. M.D.		452 N. Centre St.	2/7/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
Burial	2/9/53	Hillcrest Cemetery	Cumberland	Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 9, 1953	Minter K. Dantz, M.D.	Louis Stein Inc.	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

Dr. Dunnett

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01161

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Cumberland, Rural
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Eastman Road, R.F.D. #3

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Cumberland, Rural
STREET ADDRESS (If rural give location) Eastman Road, R.F.D. #3

3. NAME OF DECEASED: (Type or Print) (First) Russell (Middle) Calvin (Last) Perdew

4. DATE OF DEATH: (Month) (Day) (Year) February 5 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: May 6, 1899

9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Parcel Post Carrier, Ret. U.S. Post Off

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawson Perdew

14. MOTHER'S MAIDEN NAME: Mary Agnes Diehl

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Mrs. Mary E. Perdew

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241X

Immediate cause (a) Myocarditis & Decompensation — Interval Between Onset And Death: 6 mos

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Bronchial Asthma — 3 yrs

DUE TO (c) Bronchiectasis — 3 mos

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1951, to Feb. 5, 1953, that I last saw the deceased alive on Feb 3, 1953 and that death occurred at 4:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Clay R. Dunnett - M.D. ADDRESS Cumberland. DATE SIGNED 2/6/53.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Feb. 8, 1953 NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 7, 1953 REGISTRAR'S SIGNATURE Clinton K. Dantz, M.D.

24. FUNERAL DIRECTOR ADDRESS John J. Hafer, Cumberland, Maryland

VS. A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01162 4

MARGIN RESERVED FOR BINDING — PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 1day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE West Virginia — COUNTY Mineral
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Ridgeley, W.Va.
STREET ADDRESS (If rural give location) R.F.D.#I Ridgeley, W.Va.

3. NAME OF DECEASED: (Type or Print) (First) Baby (Middle) Girl (Last) Powell

4. DATE OF DEATH: (Month) (Day) (Year) 2-I-53 19

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: I-3I-53

9. AGE Last birthday: yrs. — IF UNDER 1 YEAR: Months — Days I — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cumberland, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Walter B. Powell

14. MOTHER'S MAIDEN NAME: Helen M. Peer

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Walter B. Powell R.F.D.#I Ridgeley, W.V

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

754.2

Immediate cause (a) DUE TO Intermittent Peritoneal effort + Patent Ductus arteriosus, I

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO

(c)

Interval Between Onset And Death 5 days

II OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/31, 1953, to 2/1, 1953, that I last saw the deceased alive on 2/1, 1953, and that death occurred at 9 PM, from the causes and on the date stated above.

SIGNATURE B. Mehaffie (Degree or title) MD ADDRESS 41 Baltimore Cumberland, Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-2-53 — NAME OF CEMETERY OR CREMATORY Fort Ashby Cem. — LOCATION (City, town, or county) Fort Ashby, W.Va. (State)

DATE REC'D BY LOCAL REGISTRAR Feb 2, 1953 — REGISTRAR'S SIGNATURE Hunter R. Frantz, M.D. — 24. FUNERAL DIRECTOR James F. Scarpelli — ADDRESS Cumberland, Md.

20133154 05

VS. 115

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01163

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15.

1 PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Frostburg
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Ormond St. ext.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg
STREET ADDRESS (If rural give location) Ormond St. Ext.

3. NAME OF DECEASED: (Type or Print) (First) HELEN (Middle) FRANCES (Last) PRESTON

4. DATE OF DEATH: (Month) Feb. (Day) 5, (Year) 19 53

5. SEX: female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: 10-30-1924

9. AGE last birthday: 28 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: housework

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Mt. Savage, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howard Smith

14. MOTHER'S MAIDEN NAME: Laura B. Fletcher

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 220-16-2358 none

17. INFORMANT & ADDRESS: Wm. Preston, Frostburg, Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
260X Immediate cause	(a) Acute Pancreatitis	12 hrs.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO Influenza	1 wk.
	(c) DUE TO Diabetes mellitus	1 yr.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4 Feb., 1953, to 5 Feb., 1953, that I last saw the deceased alive on 5 Feb, 1953, and that death occurred at 2:15 P.M.; from the causes and on the date stated above.

SIGNATURE (Degree or title) John B. Davis, M.D. — ADDRESS Frostburg Md — DATE SIGNED 2/7/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2-8-1953
NAME OF CEMETERY OR CREMATORY F'bg. Memorial Park
LOCATION (City, town, or county) (State) Frostburg, Md.

DATE REC'D BY LOCAL REGISTRAR 2-8-53
REGISTRAR'S SIGNATURE Mrs. Nancy N. Doe

24. FUNERAL DIRECTOR J. R. Durst, ADDRESS Frostburg, Md.

FEB
U. S.

Dr. Elinson

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01164

Reg. Dist. No. 4

Within corporate limits

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 36 Yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 134 New Hampshire Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 134 New Hampshire Avenue

3. NAME OF DECEASED: (Type or Print) (First) Albert (Middle) Theodore (Last) Reckley

4. DATE OF DEATH: (Month) Feb. (Day) 15 (Year) 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Feb. 11, 1878

9. AGE last birthday: 75 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Ret. Foreman

10b. KIND OF BUSINESS OR INDUSTRY: Md. State Roads Commission

11. BIRTHPLACE (State or foreign country): Kifer, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Roman Reckley

14. MOTHER'S MAIDEN NAME: Emma Robey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Millard Reckley, Son, LaVale, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 4 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis — 10 yrs.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/10, 19 53 to 2/15, 19 53, that I last saw the deceased alive on 2/15, 19 53, and that death occurred at 10 3/4 pm, from the causes and on the date stated above.

SIGNATURE A. E. Elinson — (Degree or title) M.D. — ADDRESS 136 Harrison St. Cumberland Md. — DATE SIGNED 2/18/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Feb. 18, 1953 — NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery — LOCATION (City, town, or county) (State) Cumberland, Maryland

DATE REC'D BY LOCAL REGISTRAR Feb. 18, 1953 — REGISTRAR'S SIGNATURE Ursula L. Franz, M.S.

24. FUNERAL DIRECTOR John J. Hafer — ADDRESS Cumberland, Maryland

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01165

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND — CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cumberland — LENGTH OF STAY (in this place) 1 wk. — HOSPITAL OR INSTITUTION OR STREET ADDRESS Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Pa. — COUNTY Somerset — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Hyndman — STREET ADDRESS (If rural give location) R. D. No 1

3. NAME OF DECEASED: (Type or Print) (First) June (Middle) Fern (Last) Reiber

4. DATE OF DEATH: (Month) 2 (Day) 7 (Year) 1953

5. SEX: F. — 6. COLOR OR RACE: W. — 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married — 8. DATE OF BIRTH: 4-28-1910 — 9. AGE last birthday: 42 yrs. — IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife — 10b. KIND OF BUSINESS OR INDUSTRY: Own home — 11. BIRTHPLACE (State or foreign country): Frostburg, Md. — 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Ernest Williams — 14. MOTHER'S MAIDEN NAME: Rose Boettner

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No — (If Yes, give war or dates of service) — 16. SOCIAL SECURITY No.: 214-07-2449 — 17. INFORMANT & ADDRESS: Mrs Leroy Peiffer, R. D. No 1 Hyndman Pa.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

1711 X

Immediate cause (a) Carcinoma Cervix — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) ..... DUE TO

(c)

Interval Between Onset And Death: 2½ yrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 15, 1953, to Feb 7, 1953, that I last saw the deceased alive on February 7, 1953, and that death occurred at 4 20 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) John A Topper MD — ADDRESS Hyndman Pa. — DATE SIGNED 2.8.53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-10-1953 — NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park — LOCATION (City, town, or county) Frostburg — (State) Md.

DATE RECD BY LOCAL REGISTRAR Feb. 7, 1953 — REGISTRAR'S SIGNATURE Walter K. Frantz, M.D. — 24. FUNERAL DIRECTOR Jacob Hafer — ADDRESS Frostburg, Md.

VS. A15 1-1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 6116C 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, if the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
MARYLAND
LENGTH OF STAY (in this place): 50 Years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Sacred Heart Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland
COUNTY: Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cumberland
STREET ADDRESS (If rural give location): 710 Bedford Street

3. NAME OF DECEASED: (Type or Print) (First) Clarence (Middle) Francis Oscar (Last) Rizer

4. DATE OF DEATH: (Month) Feb (Day) 9 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Nov 16 1879

9. AGE Last birthday: 73 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Retired Conductor

10b. KIND OF BUSINESS OR INDUSTRY: Baltimore & Ohio RR.

11. BIRTHPLACE (State or foreign country): Flintstone, Allegany Co Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin W. Rizer

14. MOTHER'S MAIDEN NAME: Amelia Dorcus

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 705 09 6114

17. INFORMANT & ADDRESS: Ernest Treat, 311 Helen St, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			Interval Between Onset And Death
331X Immediate cause	(a) DUE TO	Cerebral Hemorrhage	11 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(b) DUE TO	Hypertension	20 yrs
(260X)	(c)	Arteriosclerosis	20 yrs

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 20 years

19a. DATE OF OPERATION: **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 30, 1953, to Feb 9, 1953, that I last saw the deceased alive on Feb 8, 1953, and that death occurred at 5:35 am, from the causes and on the date stated above.

SIGNATURE (Degree or title): Samuel G. Wiseman MD — ADDRESS: 59 Greene St Cumberland Md — DATE SIGNED: Feb 11, 1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb 11 1953 — NAME OF CEMETERY OR CREMATORY: Hill Crest Burial Park — LOCATION (City, town, or county) (State): Cumberland Md.

DATE REC'D BY LOCAL REGISTRAR: Feb 11, 1953 — REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: William H. Kight — ADDRESS: Cumberland, Md.

VS. 115.

1953
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01167

CERTIFICATE OF DEATH

DR. W.F. WILLIAMS

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY ALLEGANY — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (in this place) 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
STREET ADDRESS (If rural give location) 614 BALTIMORE AVENUE

3. NAME OF DECEASED: (Type or Print) (First) EMMA (Middle) E. (Last) RUDOLPH

4. DATE OF DEATH: (Month) FEB. (Day) 27, (Year) 19 53

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED

8. DATE OF BIRTH: OCTOBER 30, 1890

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HERMAN ROMPF

14. MOTHER'S MAIDEN NAME: ANNA K. GLIME

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

480X

Immediate cause (a) DUE TO: Broncho Pneumonia (Influenza)

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO:
(c)

Interval Between Onset And Death: One day.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Portal Cirrhosis since 1950.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-20, 1950, to 2-27, 1953 that I last saw the deceased alive on 2-26, 1953, and that death occurred at 6:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) W.F. Williams M.D. ADDRESS Cumberland DATE SIGNED 2-27-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF March 2, 1953 NAME OF CEMETERY OR CREMATORY Greenmont Cemetery LOCATION (City, town, or county) Cumberland, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR March 2, 1953 REGISTRAR'S SIGNATURE Walter K. Mark, M.D. 24. FUNERAL DIRECTOR John J. Hafer, ADDRESS "

VS A15

W. M. McLane

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01168 9

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1. PLACE OF DEATH:
COUNTY Allegany MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Frostburg
LENGTH OF STAY (in this place) 1 day
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Eckhart
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) GEORGE (Middle) R. (Last) RYAN

4. DATE OF DEATH: (Month) Feb. (Day) 4, (Year) 19 53

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married

8. DATE OF BIRTH: 2-2-1880

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: retired miner

10b. KIND OF BUSINESS OR INDUSTRY: coal mines

11. BIRTHPLACE (State or foreign country): Barton, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jackson Ryan

14. MOTHER'S MAIDEN NAME: Mary Singleton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-09-6512

17. INFORMANT & ADDRESS: Mrs. Chas. Porter, Eckhart, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

241X

Immediate cause (a) acute Cardiac Dilatation — Interval Between Onset And Death: Sudden

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Bronchial Asthma — 1 week

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 3, 1953, to Feb 4, 1953, that I last saw the deceased alive on Feb 3, 1953, and that death occurred at 6.00 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Wm McLane M.D. ADDRESS Frostburg Md. DATE SIGNED 2-4-53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-6-53 — NAME OF CEMETERY OR CREMATORY Porter Cemetery — LOCATION (City, town, or county) Eckhart, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 2.6.53 — REGISTRAR'S SIGNATURE Dru Nancy N. Roe

24. FUNERAL DIRECTOR J. R. Durst, Frostburg, Md. ADDRESS

VS. A15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 11694

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 309 Water St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 309 Water St.

3. NAME OF DECEASED: (Type or Print) (First) Sallie (Middle) Ann (Last) Sherman

4. DATE OF DEATH: (Month) Feb. (Day) 20, (Year) 1953

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: 3-17-1884

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Philippi, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Jasper Bolton

14. MOTHER'S MAIDEN NAME: Lacy Markley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mr. Fenneth Sherman Rowlesburg, W. Va.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 331x

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Cerebral vascular accident	1 day
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	DUE TO (b) Cerebral thrombosis	unk.
	DUE TO (c) Generalized arteriosclerosis	

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct ..., 1952, to Feb 20, 1953, that I last saw the deceased alive on Feb 19, 1953, and that death occurred at ...m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED

Oliver Cobb Kelly M.D. Cumberland Md 2/21/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 2-23-1953

NAME OF CEMETERY OR CREMATORY Jerusalem Cemetery

LOCATION (City, town, or county) (State) Philippi, W. Va.

DATE REC'D BY LOCAL REG. Feb. 24, 1953

REGISTRAR'S SIGNATURE Minter R. Hantz, M.D.

24. FUNERAL DIRECTOR ADDRESS CHARLES L. GEORGE Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 (1170)

DR. WEISMAN

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 4-48

1. PLACE OF DEATH:

COUNTY: ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND, MD.

LENGTH OF STAY (in this place): 17 HOURS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND COUNTY: ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND

STREET ADDRESS (If rural give location): 1205 BEDFORD STREET

3. NAME OF DECEASED: (Type or Print) (First) AMANDA (Middle) A. (Last) SISK

4. DATE OF DEATH (Month) (Day) (Year): Feb. 21, 1953

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

8. DATE OF BIRTH: DEC. 12 1877

9. AGE last birthday: 75 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: None

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN DRAKE

14. MOTHER'S MAIDEN NAME: NANCY ROBINETTE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Keith Sisk, Cumberland, Md.

18. MEDICAL CERTIFICATION

		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
32 IX Immediate cause	(a) Intracerebral hemorrhage	1 week
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	DUE TO (b) Arteriosclerosis	15 yrs
240 X	DUE TO (c) Hypertension	15 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes	1½ y.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ,1948. , to Feb 21 , 1953, that I last saw the deceased alive on Feb 21 , 1953, and that death occurred at 12:10 P.M. , from the causes and on the date stated above.

SIGNATURE: A Weisman MD (Degree or title)

ADDRESS: 59 Greene St Cumberland Md

DATE SIGNED: 2/22/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Feb. 24, 1953

NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR: Feb. 23, 1953

REGISTRAR'S SIGNATURE: Wintes K. Lantz M.D.

24. FUNERAL DIRECTOR ADDRESS: William H. Kight, Cumberland, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 81171

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
LENGTH OF STAY (in this place) 2 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1007 Kent Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural give location) 1007 Kent Avenue

3. NAME OF DECEASED: (Type or Print) (First) Leroy (Middle) Earl (Last) Stapleton

4. DATE OF DEATH: (Month) Feb. (Day) 24 (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Nov. 10, 1907

9. AGE last birthday: 45 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): salesman

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Saxton, Penna.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Stapleton

14. MOTHER'S MAIDEN NAME: Florence Weaver

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.
(If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: 190-05-7798

17. INFORMANT & ADDRESS: Mrs. Thelma Stapleton, 1007 Kent Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153 x

Immediate cause (a) Argentaffinoma, small bowel — Interval Between Onset And Death: unk

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) c metastasis to bowel — DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 22 Feb, 1953, to 24 Feb, 1953, that I last saw the deceased alive on 22 Feb, 1953, and that death occurred at 1:00 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Oliver Ralph Roth, M.D. ADDRESS 202 Baltimore Cumberland Md DATE SIGNED 2/24/53

23. BURIAL, CREMATION, REMOVAL (Specify) burial

DATE THEREOF Feb. 27, 53

NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery

LOCATION (City, town, or county) (State) Johnstown, Penna.

DATE REC'D BY LOCAL REGISTRAR Feb. 24, 1953

REGISTRAR'S SIGNATURE Walter K. Frantz, M.D.

24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli-Cumberland, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

1172

Reg. Dist. No. 2

1. PLACE OF DEATH: COUNTY: Allegany; STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural near Flintstone
LENGTH OF STAY (In this place): Life
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Town Creek Road

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE: Maryland; COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Near Flintstone
STREET ADDRESS (If rural, give location): (Town Creek Road) Oldtown Md. R.1.

3. NAME OF DECEASED (Type or Print): (First) Geneve (Middle) " Bucy " (Last) Struckman
4. DATE OF DEATH: (Month) Feb. (Day) 12 (Year) 19 53

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widow
8. DATE OF BIRTH: March 17, 67
9. AGE last birthday: 85 yrs. If under 1 year: Months / Days / If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Towncreek, Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Denton Bucy
14. MOTHER'S MAIDEN NAME: Hannah Wolford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT AND ADDRESS: Shirley O Struckman, Towncreek Rd.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Acute cardiac failure — at once

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Due to Chronic Myocarditis — ?

(c) Also had Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy __, Inspection *, Inquiry * thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes *, accident __, suicide __, homicide __, undetermined __.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H.V. Deming M.D.	Cumberland, Md.	Feb. 12-1953

BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 15, 1953	IOOF Cemetery	Flintstone, Maryland.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 15, 1953	Ruth L. Bussard.	John J. Hafer,	Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

DR. W.F.WILLIAMS

CERTIFICATE OF DEATH

(1173) Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH
COUNTY: ALLEGANY — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND
LENGTH OF STAY (in this place): 19 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE: WEST VIRGINIA — COUNTY: MINERAL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: KEYSER
STREET ADDRESS (If rural, give location): 227 West Piedmont Street

3. NAME OF DECEASED (Type or Print): (First) MOLLIE (Middle) Virginia (Last) SUTER

4. DATE OF DEATH: (Month) FEBRUARY (Day) 13, (Year) 1953

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: JANUARY 31, 1874

9. AGE last birthday: 79 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM NEWMAN

14. MOTHER'S MAIDEN NAME: ELIZABETH — Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

(1)
Immediate cause (a) Chronic Myocardial Degeneration
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Bronchitis
(c) Chronic Asthma

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6.12., 1947, to 2.13.1953 that I last saw the deceased alive on 2.12., 19 53, and that death occurred at 3:15 A.m., from the causes and on the date stated above.

SIGNATURE: Wm. F. Williams — (Degree or title): M.D. — ADDRESS: Cumberland — DATE SIGNED: 2/13/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Buried	Feb. 16, 1953	Meadow Point Cemetery	Keyser, West Virginia

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 13, 1953	Walter R. Grant, M.D.	B. A. Markwood	Keyser, W. Va.

VS-A15

DR. W. F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02345

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

COUNTY: ALLEGANY — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: CUMBERLAND

LENGTH OF STAY (in this place): 2-HOURS

HOSPITAL OR INSTITUTION OR STREET ADDRESS: MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: MARYLAND COUNTY: ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: LONACONING

STREET ADDRESS (If rural, give location): Douglas Avenue

3. NAME OF DECEASED: (Type or Print) (First) Evander (Middle) DON. (Last) TAYLOR

4. DATE OF DEATH: (Month) FEB. 10 (Day) (Year) 19 53

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: JUNE 10, 1880

9. AGE last birthday: 72 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DOCTOR

10b. KIND OF BUSINESS OR INDUSTRY? Private Practice

11. BIRTHPLACE (State or foreign country): KANSAS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WARREN TAYLOR

14. MOTHER'S MAIDEN NAME: VIRGINIA M[redacted] McCleary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes — **(If Yes, give war or dates of service)** W.W.I

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Chronic Myocardial Degeneration — INTERVAL BETWEEN ONSET AND DEATH: Several years.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c) Abdomen opened several times in the past years for intestinal obstruction following gastro-enterostomy for duodenal ulcer / Last operation 1950

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2-10-53 to 2-10-53, that I last saw the deceased alive on 2-10-53, and that death occurred at 12:35 P.M., from the causes and on the date stated above.

SIGNATURE: Wm. F. Williams — (DEGREE OR TITLE) M.D. — ADDRESS: Cumberland — DATE SIGNED: 2-11-53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 12, 1953	Hillcrest Cemetery	Cumberland, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 11, 1953	Walter L. Frantz, M.D.	Geo. Eichhorn	Lonaconing,

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

Br. Dec. 45.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 0117 1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. ATD 8-51

1. PLACE OF DEATH:

COUNTY: Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: Rural OldTown

LENGTH OF STAY (in this place):

HOSPITAL OR INSTITUTION OR STREET ADDRESS: R.D.#1

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE: Md. COUNTY: Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural OldTown

STREET ADDRESS (If rural, give location): R.D.#1

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month) (Day) (Year)
Hanson	Powers	Twigg	Feb. 10, 19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	7-15-1873	79 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	Own Farm	Gilpintown, Md.	U.S.

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
Michael Twigg	Amanda Kifer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.:	17. INFORMANT & ADDRESS:
No	None	Mrs. Ralph Fuser OldTown, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

260X

Immediate cause — (a) Uraemia — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last — (b) Diabetes Mellitus Arteriosclerosis 5 yrs. — DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH: 5 mos.

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION:	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED: While at work ☐ Not while at work ☐	HOW DID INJURY OCCUR?
M.		

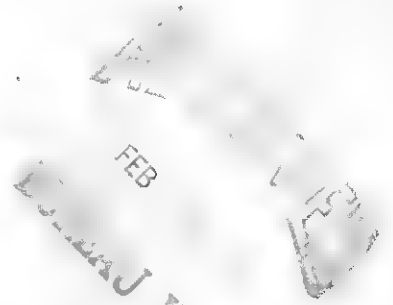
22. I hereby certify that I attended the deceased from June 7, 1952, to Feb. 10, 1953, that I last saw the deceased alive on Feb. 7, 1953 and that death occurred at .....m., from the causes and on the date stated above.

SIGNATURE: Clark L. Jones — (DEGREE OR TITLE) M.D. — ADDRESS: Cumberland — DATE SIGNED: 2/11/53

23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-13-1953	Shryock Cem.	OldTown, Md.

DATE REC'D BY LOCAL REG.: Feb. 13, 1953 — REGISTRAR'S SIGNATURE: Marie D. Twigg — 2/16/53

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.



Item 18 Film G151 2-24-53 ams

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01175 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place): 50 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 506 Springdale Street

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural give location): 506 Springdale Street

3. NAME OF DECEASED: (Type or Print) (First) Josephine (Middle) Virginia (Last) Uplinger

4. DATE OF DEATH: (Month) February (Day) 13, (Year) 19 53

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (If married, widowed, or divorced, how long?): Married

8. DATE OF BIRTH: Feb. 14, 1885

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Harpers Ferry, W. Va.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Shrewbridge

14. MOTHER'S MAIDEN NAME: Mary Finn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Ralph Uplinger, 506 Springdale St.,

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

171X
Immediate cause (a) Carcinomatosis, generalized

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Primary: Carcinoma of Cervix
DUE TO (c)

Interval Between Onset And Death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/11, 1953, to 2/13, 1953, that I last saw the deceased alive on 2/13, 1953, and that death occurred at 5:00 PM, from the causes and on the date stated above.

SIGNATURE Leo N. Levy Jr. M.D. (Degree or title) ADDRESS 456 N. Center St. DATE SIGNED Feb. 14, 1953.

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF: Feb. 16, 1953

NAME OF CEMETERY OR CREMATORY: Porter Cemetery

LOCATION (City, town, or county) (State): Fords Mills, Penna.

DATE REC'D BY LOCAL REGISTRAR: Feb. 15, 1953

REGISTRAR'S SIGNATURE: Winter R. Frantz, M.D.

24. FUNERAL DIRECTOR: James F. Scarpelli ADDRESS: Cumberland, Md.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 4

1. PLACE OF DEATH- COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland | LENGTH OF STAY (In this place): 2 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 218 Columbia St.

2. USUAL RESIDENCE (HOME) OF DECEASED- STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 218 Columbia St.

3. NAME OF DECEASED (Type or Print): (First) Charles (Middle) Lester (Last) Valentine
4. DATE OF DEATH: (Month) Feb. (Day) 18 (Year) 1953

5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): single
8. DATE OF BIRTH: Jan. 17-1902
9. AGE Last birthday: 51 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unable to work
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cumberland, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Valentine
14. MOTHER'S MAIDEN NAME: Leslie Walsh

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: brother) Walter Valentine, Cumberland Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause	(a) Coronary occlusion due to	at once
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) Coronary sclerosis	?
	(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Partial paraplegia — 2o yrs

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, OF INJURY office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy __, Inspection *, Inquiry * thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes *, accident __, suicide __, homicide __, undetermined __.*

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
H.V. Deming M.D.	H.V. Deming M.D.	Cumberland, Md.	Feb. 19-1953

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2-21-1953	Zion Memorial Cem.	Cumberland, Md.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 20, 1953	Wilter R. Frantz, M.D.	Charles L. George	Cumberland, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct name and especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

DR. DURRETT

CERTIFICATE OF DEATH

Reg. Dist. No. 01177 4

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE

VS. A15

1. PLACE OF DEATH:

COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,

LENGTH OF STAY (in this place) 316 DAYS

HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MARYLAND.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY ALLEGANY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND

STREET ADDRESS (If rural give location) 215 SOUTH CENTER ST.,

3. NAME OF DECEASED: (Type or Print) (First) ALICE (Middle) G. (Last) VAN HORN

4. DATE OF DEATH: (Month) FEB. (Day) 21 (Year) 19 53

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday:	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	SINGLE	SEPT. 21, 1890	62 yrs.				

KKB

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housework	Own home	MARYLAND Cumberland,	U. S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
GEORGE W. VAN HORN	DOROTHY MC CREARY

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No		None	Mr. Ishmael Van Horn 36 Wempe Dr. Comb. Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 422.2 Uraemia — Interval Between Onset And Death 3 mos.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Myocarditis — 3 yrs.

DUE TO

(c)

II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov. 52, to Feb. 20, 19 53, that I last saw the deceased alive on Feb. 20, 1953 and that death occurred at 11:40 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title)	ADDRESS	DATE SIGNED
Clay S. Durrett M.D	Cumberland	2/22/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	2/24/53	Trinity Lutheran	Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 24, 1953	Winter R. Baetz, M.D.	H. Wayne George	Cumberland, Md.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

01178

Reg. Dist. No. .....

VS. A16-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH
COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville
LENGTH OF STAY (in this place) 30 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED
STATE Maryland COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Corriganville
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): (First) Adolph (Middle) W. (Last) Von Kaske

4. DATE OF DEATH: (Month) Feb. (Day) 17, (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Feb. 3, 1872

9. AGE last birthday: 81 yrs. If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister

10b. KIND OF BUSINESS OR INDUSTRY: Ministry

11. BIRTHPLACE (State or foreign country): Cleveland, Ohio

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Von Kaske

14. MOTHER'S MAIDEN NAME: Julia Sharnock

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 212 12 8458

17. INFORMANT AND ADDRESS: Mrs. A.W.VonKaske, Corriganville, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42 : 2

Immediate cause (a) Chronic Myocardosis — Interval between onset and death: 10 yrs.

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last
(b)
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR?

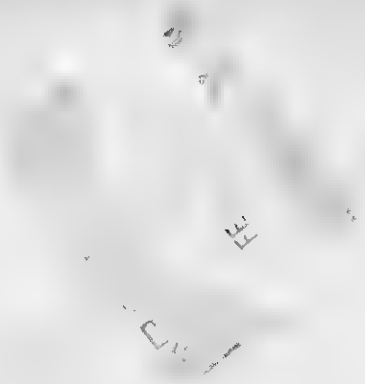
22. I hereby certify that I attended the deceased from Jan. 17, 1953, to 2/17/53, 19....., that I last saw the deceased alive on 2/17/53, 19..., and that death occurred at 7:30 A. m., from the causes and on the date stated above.

SIGNATURE: John A Lapper (Degree or title) MD ADDRESS: Hyndman Pa DATE SIGNED: 2/17/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial | DATE THEREOF: Feb. 20, 1953 | NAME OF CEMETERY OR CREMATORY: St. Luke's Cemetery | LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG. 2-19-53 | REGISTRAR'S SIGNATURE: Edward Wolfe

24. FUNERAL DIRECTOR: Harvey H. Zeigler, ADDRESS: Hyndman, Pa.



Within corporate limits ITEM 3: film G151 3-9-53 L

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 [illegible]79

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 813 Fayette St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 813 Fayette St.

3. NAME OF DECEASED: (First) William (WILL) (Middle) Worley (Last) Waddell
(Type or Print)

4. DATE OF DEATH: (Month) Feb. (Day) 13, (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 4-4-1884

9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Distr.

10b. KIND OF BUSINESS OR INDUSTRY: Store Equipement

11. BIRTHPLACE (State or foreign country): Lamira, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Frank S. Waddell

14. MOTHER'S MAIDEN NAME: Mary B. Parkinson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) War I

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: Mrs. Mary Waddell Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

4201

Immediate cause (a) Coronary Thrombosis — DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Chronic myocarditis — DUE TO

(c) degeneration

INTERVAL BETWEEN ONSET AND DEATH: Sudden

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-1-, 19 34, to 2-13, 19 53, that I last saw the deceased alive on 1-7, 19 53, and that death occurred at 3:30 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Wm. F. Williams M.D. Cumberland 2/14/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: 2-16-1953 — NAME OF CEMETERY OR CREMATORY: Union Cemetery — LOCATION (City, town, or county) (State): St. Clairsville, Ohio.

DATE REC'D BY LOCAL REG.: Feb. 14, 1953 — REGISTRAR'S SIGNATURE: Winter R. Hartz, M.D.

24. FUNERAL DIRECTOR: Charles L. George — ADDRESS: Cumberland, Md.

VS-A15 8-51

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01180

DR. R. WILLIAMS

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND
LENGTH OF STAY (In this place) 2 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND,
STREET ADDRESS (If rural give location) 316 PRINCE GEORGE STREET

3. NAME OF DECEASED: (Type or Print) (First) SAMUEL (Middle) H. (Last) WELSHANS

4. DATE OF DEATH: (Month) FEBRUARY (Day) 26, (Year) 19 53

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): MARRIED

8. DATE OF BIRTH: OCT. 14, 1890

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Machinist

10b. KIND OF BUSINESS OR INDUSTRY: B. & O. RAILROAD

11. BIRTHPLACE (State or foreign country): WEST VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY WELSHANS

14. MOTHER'S MAIDEN NAME: SALLY RUSSLER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: MEMORIAL HOSPITAL - CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 442X Hypertensive Cardio Vascular renal disease — Interval Between Onset And Death: Since 2-1951

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) ... DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-20 ..., 19 52, to 2-26, 19 53, that I last saw the deceased alive on 2-25, 1953, and that death occurred at 1:15 A.M., from the causes and on the date stated above.

SIGNATURE Wm. R. Williams (Degree or title) M.D. ADDRESS Cumberland DATE SIGNED 2/26/53.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF March 1, 1953 NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park LOCATION (City, town, or county) (State) Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR Feb 27, 1953 REGISTRAR'S SIGNATURE Walter L. Lantz, M.D.

24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland, Md.

VS. 415 T

DR. WHITWORTH

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age in especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY ALLEGANY — STATE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN CUMBERLAND — LENGTH OF STAY (in this place) 9 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS MEMORIAL HOSPITAL CUMBERLAND, MD.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND — COUNTY ALLEGANY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN FLINTSTONE
STREET ADDRESS (If rural, give location) BOX-60-A ROUTE # 2

3. NAME OF DECEASED (Type or Print): (First) VIOLET (Middle) O. (Last) WILMOT

4. DATE OF DEATH: (Month) FEB. (Day) 8, (Year) 53

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED

8. DATE OF BIRTH: 3/17/1896

9. AGE last birthday: 56 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: MARION RICE

14. MOTHER'S MAIDEN NAME: MARIAH WILSON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT AND ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Carcinomatosis Generalized Abdominal

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Carcinoma Cervix

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Vesico Vaginal Fistula

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION: Generalized pelvic Carcinomatosis — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at Work ☐ Not While At work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-22, 19.51, to 2-7-53, 19.53, that I last saw the deceased alive on 2-7-53, 19.53, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

Fuller B. Whitworth M.D. — 125 Bedford St — 2-7-53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: 2-11-1953 — NAME OF CEMETERY OR CREMATORY: Mt. Herman — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 11, 1953 — REGISTRAR'S SIGNATURE: Anita R. Lantz, M.D. — 24. FUNERAL DIRECTOR — ADDRESS: Charles L. George Cumberland, Md

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01182

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN Cumberland — LENGTH OF STAY (in this place) 5 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rockfield St.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) Leland St.

3. NAME OF DECEASED: (Type or Print) (First) Lathiny (Middle) Araminta (Last) Kirkbride

4. DATE OF DEATH. (Month) 2 (Day) 22 (Year) 1953

5. SEX: F. | 6. COLOR OR RACE: W. | 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Widowed | 8. DATE OF BIRTH: 6/24/1875 | 9. AGE last birthday: 77 yrs. (IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min.)

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housework | 10b. KIND OF BUSINESS OR INDUSTRY: Own Home | 11. BIRTHPLACE (State or foreign country): Hungerford, W. Va. | 12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Alfred LeVault | 14. MOTHER'S MAIDEN NAME: Louise Lamar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: None | 17. INFORMANT & ADDRESS: Mrs. Lucretia Light, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Carcinoma of Stomach — DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) [illegible] — DUE TO

(c)

Interval Between Onset And Death: 1-2 yrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis Heart Disease

19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/3 ,19 52 to 2/22 , 19 53, that I last saw the deceased alive on 2/22 , 19 53 and that death occurred at 4 PM , from the causes and on the date stated above.

SIGNATURE (Degree or Title) Jerry Leland Jr. — ADDRESS Lonaconing — DATE SIGNED 2/23/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 2-25-1953 — NAME OF CEMETERY OR CREMATORY Frostburg Memorial Park — LOCATION (City, town, or county) Frostburg, Md. — (State)

DATE REC'D BY LOCAL REGISTRAR 2-24-53 — REGISTRAR'S SIGNATURE Jeannette M Boal — 24. FUNERAL DIRECTOR Cecil Kaye — ADDRESS Frostburg, Md.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01183

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15 8-51

1. PLACE OF DEATH:
COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN: Cumberland
LENGTH OF STAY (In this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 612 Montgomery Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Md. COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Cumberland
STREET ADDRESS (If rural, give location): 612 Montgomery Ave.

3. NAME OF DECEASED: (Type or Print) (First) Leo (Middle) Walter (Last) Witherup

4. DATE OF DEATH: (Month) Feb. (Day) 10, (Year) 19 53

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: 11-7-1887

9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tire Adjuster

10b. KIND OF BUSINESS OR INDUSTRY: Rubber

11. BIRTHPLACE (State or foreign country): Akron, Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Robert M. Witherup

14. MOTHER'S MAIDEN NAME: Mary Hartz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-07-0441

17. INFORMANT & ADDRESS: Mrs. Martha Witherup Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Acute heart attack most

Immediate cause (a) Lobular dilatation & thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) Old myocarditis · Malnutrition

DUE TO

(c) Cardio-renal vascular syndrome

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

(CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 19 52, to Feb. 10, 19 53, that I last saw the deceased alive on Feb. 10, 19 53, and that death occurred at 10 A. M., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

Charles R. Everhart M.D. 36 Greene St Cumberland Md 2/12/53

23. BURIAL, CREMATION REMOVAL (Specify): Burial

DATE THEREOF: 2-13-1953

NAME OF CEMETERY OR CREMATORY: HillCrest Burial Park

LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 13, 1953

REGISTRAR'S SIGNATURE: Walter L. Hartz, M.D.

24. FUNERAL DIRECTOR ADDRESS: Charles L. George Cumberland, Md.

Dr. Richard Wms.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01121

1. PLACE OF DEATH:
COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 2, Cumberland
LENGTH OF STAY (in this place): 38 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route 2, Lonaconing, Md.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 2, Cumberland, Maryland
STREET ADDRESS (If rural give location): Route 2, Lonaconing, Maryland

3. NAME OF DECEASED: (Type or Print) (First) Lewis (Middle) Grant (Last) Yaider

4. DATE OF DEATH: (Month) February (Day) 13 (Year) 1953

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Sept. 10, 1874

9. AGE last birthday: 78 yrs. IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Ret. Farmer

10b. KIND OF BUSINESS OR INDUSTRY: General Farmer

11. BIRTHPLACE (State or foreign country): Winchester, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Yaider

14. MOTHER'S MAIDEN NAME: Mary Ellen Wolford

15. WAS DECEASED EVER IN U.S ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: None

17. INFORMANT'S ADDRESS: William B. Yaider, Son Rt 2 Cumb. Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

422.1

Immediate cause (a) Art. Sclerotic Cardiovascular Disease — 5 yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Myocarditis Chr — 2 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) Cumberland — (COUNTY) Alleg — (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8/14/52, 19, to 2/13/53, 19, that I last saw the deceased alive on 2/13/53, 19, and that death occurred at 11:55 m. from the causes and on the date stated above.

SIGNATURE (Degree or title) W. H. Wilson M.D. — ADDRESS Cumberland — DATE SIGNED 2/14/53

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF Feb. 16, 1953 — NAME OF CEMETERY OR CREMATORY Mt. Herman Meth. Com. — LOCATION (City, town, or county) Near Cumberland, Md. (State)

DATE REC'D BY LOCAL REGISTRAR Feb. 16, 1953 — REGISTRAR'S SIGNATURE Nina A. Sender — 24. FUNERAL DIRECTOR ADDRESS John J. Hafer, Cumberland, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

01185

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1. PLACE OF DEATH:

COUNTY Allegany — MARYLAND

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 1, Cumberland, Rural

LENGTH OF STAY (in this place): 20 years

HOSPITAL OR INSTITUTION OR STREET ADDRESS: 28. LaVale St Rt 1.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland — COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Route 1, Cumberland, Rural

STREET ADDRESS (If rural give location): 28 LaVale St Rt 1.

3. NAME OF DECEASED: (Type or Print) (First)	(Middle)	(Last)	4. DATE OF DEATH: (Month) (Day) (Year)
PHILLIP		YASTE	FEB. 2, 19 53

5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	June 27, 1876	76 yrs.		

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
Store Operator	Bakery	Frostburg, Md.	USA

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:
James Yaste	Sarah Harden

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
No	213-12-9154	Alvin Yaste, Route 1, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) DUE TO: Uremic Coma

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) DUE TO: Senility. Hypotentrum Cardio-Renal Vascular Syndrome

(c)

Interval Between Onset And Death: √ Days

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY	m.	INJURY OCCURED While at Work ☐ Not While At Work ☐	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19 40, to Feb 2, 19 53, that I last saw the deceased alive on Feb 2, 19 53, and that death occurred at 5-25 PM from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
Lysle R. Eichart	M.D.	31 Greene St Cumberland	2/2/53

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 4, 1953	Hill Crest Burial Park	Cumberland, Md.

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb. 4, 1953	Walter R. Beantz, M.D.	William H. Kight, Cumberland, Md.	

RECEIVED
FEB 10 1953
BUREAU V. S.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

01186

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

1. PLACE OF DEATH: COUNTY Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland — LENGTH OF STAY (In this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Dead on arrival at the Memorial Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. COUNTY Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland
STREET ADDRESS (If rural, give location) 159 Bedford St.

3. NAME OF DECEASED (Type or Print): (First) Estella (Middle) M. (Last) Zihlman
4. DATE OF DEATH: (Month) Feb. (Day) 24 (Year) 1953
5. SEX: femal
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: April 18-1886
9. AGE last birthday: 66 yrs. — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Levels, W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Durst
14. MOTHER'S MAIDEN NAME: Lucy Day
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT AND ADDRESS: daughter) Mary Dicken, Cumberland, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (e) Coronary occlusion due to — at once

420.1

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Coronary sclerosis — ?

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐*

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. — PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY — (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐*, Inquiry ☐* thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐*, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

H.V.Deming M.D. H. V. Deming M.D. Cumberland, Md. Feb. 24-1953

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Feb. 27 1953 — NAME OF CEMETERY OR CREMATORY: Hillcrest Cem — LOCATION (City, town, or county) (State): Cumberland, Md.

DATE REC'D BY LOCAL REG.: Feb. 26, 1953 — REGISTRAR'S SIGNATURE: Walter R. Fantz, M.D. — 24. FUNERAL DIRECTOR: William A. Kight, Cumberland — ADDRESS

Kight.

RECEIVED
MAR 3 1953
BUREAU V. S.